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No. 93-115

Supreme Court, U.S.
FILED
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

NYSA-ILA WELFARE FUND, by its Trustees, JOHN BOWERS, ALBERT CERNADAS, FRANK LONARDO, THOMAS POPOLA, JAMES CAPO, JOSEPH N. BARBERA, BART DiMATTINA, and RICHARD H. O'NEILL,

Petitioner,

v.

FRANCIS J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; AND COLUMBUS HOSPITAL, EAST ORANGE GENERAL HOSPITAL, ST. JAMES HOSPITAL, and UNIVERSITY HOSPITAL, individually and as Class Representatives of Hospitals in the State of New Jersey; and NEW JERSEY HOSPITAL ASSOCIATION, as Class Representative of Hospitals in the State of New Jersey,

Respondents.

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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Filed May 14, 1993

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 92-5317/5319/5320/
5341/5343/5345/5352/5354/5355

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; JACK STOLL; ESTHER BORJA; JAVIER RESTREPO; UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION LOCAL 464A, AFL-CIO GROUP REIMBURSEMENT WELFARE PLAN; FRANK LACATENA; DOLORES LACATENA; NEW JERSEY CARPENTERS WELFARE FUND; LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; TRUSTEES OF THE LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; PROSPER ALEXANDER; MARIE ALEXANDER; DISTRICT COUNCIL OF IRONWORKERS OF NORTHERN NEW JERSEY WELFARE FUND; ARCHIE G. FERGUSON; RONALD W. JENSEN; JOHN J. IRVINE; WALTER PHILLIPS; MICHAEL J. MCDERMOTT; SAMUEL PACICH; ALBERT J. IRWIN; NICHOLAS J. ANDRETTA, SR.; GARY UGARO; WALTER F. STEINMETZ; JOHN D. MULVANY; MICHAEL W. FEATHERSON; FRANCIS E. ARNY; JOHN J. CLARK, SR.; RONALD W. WILLIAMS; DANIEL J. PEREZ; KEITH E. ZDEP; EDWARD WEIDLER; LOUIS ROCCO; RAYMOND J. RODGERS; FRANCIS J. AKESSON; DONALD J. BANTA, SR.; CHARLES W. BIRD; DAVID F. BROWN; CLIFFORD CROOKS; ROBERT T. CUSICK; JAMES P. FITZGERALD; JOSEPH A. FUSARO; CHARLES GAMBA; RICHARD GOUGEON; JOHN KEATING; GERARD MCCLOUD; ROBERT MCGEE; ALEXANDER MCLELLAN; JOHN MURPHY; LAURENCE O'BRIEN; PETER O'CONNER; RAUL RODRIGUEZ; ROBERT SCHWEITZER; ROBERT SICKLES; ANDREW L. SMITH; RICHARD SPARKS; GEORGE SUDAK; EDWARD TEDESCO; JAMES TOAL; ENOCH P. MCMAHON; LOCAL UNION 400; IBEW WELFARE FUND;

BRIAN HRUSKA; WILLIAM MARSH; CHARLES WORK; HAROLD RUTLEDGE; RALPH ALLEN; THOMAS VADAS; VINCENT WORTH; TIMOTHY HILL; RONALD RAMSEY; JOHN IRELAND; JAMES MARTIN; MICHAEL ALMASI; BEVERLY A. RUBY; PETER NAMOTKA; DANIEL KENNEDY; GEORGE COLE; WALTER DAVIES; ROBERT HERMANN; FRANK HERMANN; CHARLES KELLER; DENNIS JOHNSON; CONNIE J. KOEHLER; FRANK O'DAY; VINCENT LA STELLA; DONALD MCNEIL; JEAN-LOUIS POULIOT; NICHOLAS AEMISEGO; ROBERT STAHNKE; PHILIP CERZA; GARY GIORGIO; EDWARD OSOWSKI; GLENN HALVORSEN; WILLIAM STADELMAN; DANIEL JULIO, JR.; FRANCIS ALEXANDER; LEONARD DAHL; MICHAEL DEVINE; JOSEPH GEORGE; RALPH JENSEN; DONALD LA BRUTTO; NORMAN GRAMLICH; JUAN ROMERO; JOSEPH PIWOSKI; HARRY PEASE, JR.; EUGENE O'ROURKE; PAUL NIEDZINSKI; BERNARD WALL; STEPHEN KOJAC; CHARLES KRUPKA; WILLIAM MCCORMACK; MINOR KENNARD; STEPHEN J. SANGLE; DONALD SCHIRALDO; JOHN GACINA, III; BRIAN MCCARTHY; CHARLES MCNALLY; ROBERT CZAJOWSKI; BRIAN WOODALL; JEFFREY STAHNKE; JOHN RYAN; RALPH ROSAMILIA, SR.; DANIEL MUGAN; EDWARD MIRONSKI; MICHAEL MIDDINGS; ANDREW MAHASKY; WALTER JELINSKY; ALBERT GAECHTER; LOUIS DI MASCIO; ELLIOTT ROSEMAN; TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; RICHARD HORNECKER; TEAMSTERS LOCAL 11 BENEFIT PLAN; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; KATLUSKA BAIDAL; WILLIAM BARTEL; GUNTER BLOHM; ANGELO BUINNO; BETTY J. CAIRNS; FRANK CLOSE; JOSE CRUZ; SANTOS GARCIA; KAREN GENSURE; DOROTHY LARSON; RICHARD LITCHFIELD; SANDRA MARINO; JOHN MATUSZKIEWICZ; GEORGE MCCLAUGHLIN; OLGA MONTES; FERNANDO PEREZ; SANTO RAMOS; MARTHA SARA; ROXEEN SCALA; EDMUND SCOTT; CHARLIE TAYLOR; MELISSA TURI, SANGPO TSULDIN; COSMO VISENTINI; NYSA-ILA WELFARE FUND; JOHN BOWERS; ALBERT CERNADAS; FRANK LONARDO; THOMAS POPOLA; JAMES CAPO; JOSEPH N. BARBERA; BART DIMATTINA; RICHARD H.

O'NEILL; LABORERS INTERNATIONAL UNION OF NORTH AMERICA LOCAL 415 HEALTH AND WELFARE FUND; SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND; JEFFREY STAJEK; JAMES LUCIANO; JOHN A. FREUDENREICH, SR.; THOMAS SMIECH; JOSEPH MCCALLION; DANIEL SMITH, JR.; JAMES MCKAY; MARK COX; TRUSTEES OF THE TEAMSTERS LOCAL 641 WELFARE FUND; CARLOS ROCHA; GEORGE KOESTER; CARMELA FERENS; KHOONRAJIE RAGHUBANS; PHILLIP SAVITTIERI; EAR PATTERSON; ROBERT REEDER; LOCAL 1245, LOCAL 1245 HEALTH FUND; ANTHONY RIZZO; JOSEPH ABBATE; JOSEPH MASSOUD; RALPH MASTRANGELO; TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475; WILLIE A. BARNES; HERMAN GEIGER; VINSTON LEE KING; KEVIN E. KLINE; ROBERT L. ROSA; WILLIAM BRENNAN; JAMES MURPHY, JR.; PATRICIA MCELLIGOTT; KEVIN MCCORMICK; PATRICK RYAN, JR.; ANTHONY E. SMITH; ROBERT LAVERATT; JOHN S. WITTEK; JOHN MCQUILKEN; JOHN MONTESANO; ROY E. FRANK; JOHN O'NEILL, JR.; FRANK ROBINSON; DALE SCHAEFER; JOHN J. SERRA; DONALD SHERIDAN; WENCESLAO SOTO; MICHAEL J. RUSSO; JOSEPH P. MURPHY, JR.; CALVIN R. SUTTON, III; RONALD J. ZAKARZEWSKI; FRANK WHITNEY, SR.; JACK NACHTIGALL; LAWRENCE PARKIN; EDISON RODRIQUEZ; WILLIAM MORAN; VINCENT DOFFONT; GEORGE STOUT; BRIAN LUBECK; AMERICO GUGLIELMO; DAVID VADAS; CHRISTOPHER ANDREWSKI; DAVID JENKINS; ARTHUR ACKERMAN; KENNETH FINTON; RAMON LORENZO; WESLEY SANDERSON; CHARLES NEWMAN, III; LEONARD IAROSSI; GEORGE ROSSI; WILLIAM SKIECZIUS; JOHN HANCOCK; EDWARD THORNE; JOSEPH TAGLIADIA; MICHAEL MACHANSKA; STEVE PARLACASK

v.

MORRISTOWN MEMORIAL HOSPITAL; FRANCES J. DUNSTON; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; NEW JERSEY COMMISSIONER OF HEALTH; FRANCES DUNSTON; MEMORIAL HOSPITAL OF BURLINGTON COUNTY; THE MEDICAL CENTER OF OCEAN COUNTY;

KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; OUR LADY OF LOURDES HOSPITAL; PRINCETON MEDICAL CENTER; HOSPITAL OF SALEM COUNTY; NEWCOMB MEDICAL CENTER; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; SHORE MEMORIAL HOSPITAL; BURDETTE TOMLIN MEMORIAL HOSPITAL; CHRIST HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; WAYNE GENERAL HOSPITAL; SOUTH JERSEY HOSPITAL SYSTEM; COOPER HOSPITAL; WEST JERSEY HEALTH SYSTEMS; ATLANTIC CITY MEDICAL CENTER; UNION MEMORIAL HOSPITAL; ELIZABETH GENERAL HOSPITAL; ENGLEWOOD HOSPITAL; ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; BARNERT MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL; RAHWAY HOSPITAL; VALLEY HOSPITAL; HOLY NAME HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; OVERLOOK HOSPITAL; ST. ELIZABETH HOSPITAL; DOVER GENERAL MEDICAL CENTER; HUNTERDON MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; KESSLER MEMORIAL HOSPITAL; FREEHOLD AREA HOSP.; KENNEDY MEMORIAL HOSPITAL; UNIVERSITY HOSPITAL; UNDERWOOD MEMORIAL HOSPITAL; JERSEY CITY MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; ST. BARNABAS MEDICAL CENTER; RARITAN BAY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; ST. CLARES/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; HACKETTSTOWN COMMUNITY HOSPITAL; ZURBRUGG MEMORIAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; MONMOUTH MEDICAL CTR; NEWTON MEMORIAL HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; DEBORAH HEART AND LUNG CENTER; HOSPITAL CENTER AT ORANGE; DOVER GENERAL HOSPITAL; WEST JERSEY HEALTH SYSTEM; RARITAN BAY MEDICAL CENTER; HACKENSACK MEDICAL CENTER; SOUTH AMBOY MEMORIAL HOSPITAL; THE MOUNTAINSIDE HOSPITAL; ST. FRANCIS HOSPITAL; BAYONNE HOSPITAL; MUHLENBERG HOSPITAL; CENTRASTATE (FAH) HOSPITAL, ST. JAMES HOSPITAL; KENNEDY MEMORIAL HOSPITAL AT SADDLE

BROOK; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DIVISION) OF MEDICAL ASSISTANCE AND HEALTH SERVICES; ELIZABETH GENERAL MEDICAL CENTER; DOVER GENERAL MEDICAL CENTER; IRVINGTON GENERAL HOSPITAL; UNION HOSPITAL; WARREN HOSPITAL, COLUMBUS HOSPITAL; EAST ORANGE GENERAL HOSPITAL, FRANCIS DUBEAU; LILLIAN DUBEAU; BAYSHORE COMMUNITY HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION; BERGEN PINES COUNTY HOSPITAL; COMMUNITY MEMORIAL HOSPITAL; GREENVILLE HOSPITAL; MONTCLAIR COMMUNITY (HOSPITAL) PALISADES GENERAL HOSPITAL; PASSAIC BETH ISRAEL HOSPITAL; RARITAN BAY MEDICAL CENTER/PERTH AMBOY DIVISION; RIVERVIEW MEDICAL CENTER; SOUTHERN OCEAN COUNTY HOSPITAL; ST. MARY'S HOSPITAL; THE GENERAL HOSPITAL CENTER AT PASSAIC; WALLKILL VALLEY HOSPITAL AND HEALTH CENTERS; ST. MARY'S HOSPITAL (PASSAIC); UNITED HOSPITAL; PASCACK VALLEY HOSPITAL; WEST HUDSON HOSPITAL; JOHNSON UNIVERSITY HOSPITAL; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; NEW JERSEY HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION,

Intervenor-Defendants

(Newark New Jersey District Consolidated Lead Civil No. 90-02639)

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; ESTHER BORJA

v.

ST. MARY'S HOSPITAL HOSPITAL; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; FRANCES J. DUNSTON;

(Newark New Jersey District Civil No. 90-03640)

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; JAVIER RESTREPO

v.

ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-00073)

UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION, LOCAL 464A, AFL-CIO GROUP REIMBURSEMENT WELFARE PLAN; FRANK LACATENA; DOLORES LACATENA

v.

WAYNE GENERAL HOSPITAL; FRANCES J. DUNSTON; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-00336)

DISTRICT COUNCIL OF IRONWORKERS OF NORTHERN NEW JERSEY WELFARE FUND; ARCHIE G. FERGUSON; RONALD W. JENSEN; JOHN J. IRVINE, WALTER PHILLIPS; MICHAEL J. MCDERMOTT; SAMUEL PACICH; ALBERT J. IRWIN, NICHOLAS J. ANDRETTA, SR.; GARY UGARO; WALTER F. STEINMETZ; JOHN D. MULVANEY; MICHAEL W. FEATHERSON; FRANCIS E. ARNY; JOHN J. CLARK, SR.; RONALD W. WILLIAMS; DANIEL J. PEREZ; KEITH E. ZDEP; EDWARD WEIDLER; LOUIS ROCCO; RAYMOND J. RODGERS; FRANCIS J. AKESSON; DONALD J. BANTA, SR; CHARLES W. BIRD; DAVID BROWN; CLIFFORD CROOKS; ROBERT T. CUSICK; JAMES P. FITZGERALD; JOSEPH A. FUSARO; CHARLES GAMBA; RICHARD GOUGEON; JOHN KEATING; GERARD MCCLOUD; ROBERT MCGEE; ALEXANDER MCLELLAN; JOHN MURPHY; LAURENCE O'BRIEN; PETER O'CONNER; RAUL RODRIGUEZ; ROBERT SCHWEITZER; ROBERT SICKLES; ANDREW L. SMITH;

RICHARD SPARKS; GEORGE SUDAK; EDWARD TEDESCO; JAMES TOAL; ENOCH P. MCMAHAN

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; DEBORAH HEART AND LUNG CENTER; HUNTERDON MEDICAL CENTER; ST. FRANCIS HOSPITAL; HOSPITAL CENTER AT ORANGE; ST. PETERS MEDICAL CENTER; ST. CLARES/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; DOVER GENERAL HOSPITAL; ST. BARNABAS MEDICAL CENTER; VALLEY HOSPITAL; OVERLOOK HOSPITAL; RAHWAY HOSPITAL; NEWTON MEMORIAL HOSPITAL; WEST JERSEY HEALTH SYSTEM; RARITAN BAY MEDICAL CENTER; HACKENSACK MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; HOLY NAME HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; BAYONNE HOSPITAL; CHILTON MEMORIAL HOSPITAL; ST. JOSEPH'S HOSPITAL; MUHLENBERG HOSPITAL; COMMUNITY MED CENTER; CHRIST HOSPITAL; SOUTH AMBOY MEMORIAL HOSPITAL; CENTRASTATE (FAH) HOSPITAL; WAYNE GENERAL HOSPITAL; PRINCETON MEDICAL CENTER; ST. JAMES HOSPITAL,a/k/a CATHEDRAL HEALTH SERVICES, INC.; MOUNTAINSIDE HOSPITAL; PASSAIC GENERAL HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-02190)

NEW JERSEY CARPENTERS WELFARE FUND

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; SOUTH JERSEY HOSPITAL SYSTEM; COOPER HOSPITAL; WEST JERSEY HEALTH SYSTEMS; ATLANTIC CITY MEDICAL CENTER; MEMORIAL HOSPITAL OF BURLINGTON COUNTY; THE MEDICAL CENTER OF OCEAN COUNTY; KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; OUR LADY OF

LOURDES; PRINCETON MEDICAL CENTER; HOSPITAL OF SALEM COUNTY; NEWCOMB MEDICAL CENTER; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; SHORE MEMORIAL HOSPITAL; BURDETTE TOMLIN MEMORIAL; CHRIST HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; WAYNE GENERAL HOSPITAL; UNION MEMORIAL HOSPITAL; ELIZABETH GENERAL HOSPITAL; ENGLEWOOD HOSPITAL, ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; BARNERT MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL; RAHWAY HOSPITAL; THE VALLEY HOSPITAL; HOLY NAME HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; OVERLOOK HOSPITAL; ST. ELIZABETH HOSPITAL; DOVER GENERAL MEDICAL CENTER; HUNTERDON MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; KESSLER MEMORIAL HOSPITAL; FREEHOLD AREA HOSPITAL; KENNEDY MEMORIAL HOSPITAL; UNIVERSITY HOSPITAL; UNDERWOOD MEMORIAL HOSPITAL; JERSEY CITY MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; ST. BARNABAS MEDICAL CENTER; RARITAN BAY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; ST. CLARE'S/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; HACKETTSTOWN COMMUNITY HOSPITAL; ZURBRUGG MEMORIAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; MONMOUTH MEDICAL CENTER; NEWTON MEMORIAL HOSPITAL; NEW JERSEY HOSPITAL, NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-03280)

LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; TRUSTEES OF THE LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; PROSPER ALEXANDER; MARIE ALEXANDER

v.

UNIVERSITY HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; FRANCES J. DUNSTON, in

her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-03286)

LOCAL UNION 400, IBEW WELFARE FUND; BRIAN HRUSKA; WILLIAM MARSH; CHARLES WORK; HAROLD RUTLEDGE; RALPH ALLEN; THOMAS VADAS; VINCENT WORTH; TIMOTHY HILL, RONALD RAMSEY; JOHN IRELAND; JAMES MARTIN

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; THE MEDICAL CENTER OF OCEAN COUNTY; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; JERSEY SHORE MEDICAL CENTER; KIMBALL MEDICAL CENTER; MONMOUTH MEDICAL CENTER NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-03897)

OVERLOOK HOSPITAL

v.

FRANCES DUBEAU; LILLIAN DUBEAU

(Newark New Jersey District Civil No. 91-03910)

LABORERS INTERNATIONAL UNION OF NORTH AMERICA LOCAL 415 HEALTH AND WELFARE FUND

v.

FRANCES J. DUNSTON. in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-04078)

NYSA-ILA WELFARE FUND, by its Trustees; JOHN BOWERS, Trustee; ALBERT CERNADAS, Trustee; FRANK LONARDO, Trustee; THOMAS POPOLA, Trustee; JAMES CAPO, Trustee;

JOSEPH N. BARBERA, Trustee; BART DIMATTINA, Trustee; RICHARD H. O'NEILL, Trustee

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; COLUMBUS HOSPITAL; EAST ORANGE GENERAL HOSPITAL ST. JAMES HOSPITAL; UNIVERSITY HOSPITAL, Individually and as Class Representatives of Hospitals in the State of New Jersey; NEW JERSEY HOSPITAL ASSOCIATION,
as Class representative of Hospital in the State of New Jersey

(Newark New Jersey District Civil No. 91-04259)

SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND; JEFFREY STAJEK; JAMES LUCIANO; JOHN A. FREUDENREICH, SR.; THOMAS SMIECH; JOSEPH MCCALLION; DANIEL SMITH, JR.; JAMES MCKAY; MARK COX

v.

FRANCES J. DUNSTON, in her capacity of New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DIVISION) OF MEDICAL ASSISTANCE AND HEALTH SERVICES; NEW JERSEY HOSPITAL ASSOCIATION; ST. BARNABAS MEDICAL CENTER; HOLY NAME HOSPITAL; HACKENSACK MEDICAL CENTER; WEST HUDSON HOSPITAL; OVERLOOK HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; HUNTERDON MEDICAL CENTER; MORRISTOWN MEMORIAL HOSPITAL; IRVINGTON GENERAL HOSPITAL; CLARA MAASS MEDICAL CENTER

(Newark New Jersey District Civil No. 91-04700)

TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; RICHARD HORNECKER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT

OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND, NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

(Newark New Jersey District Civil No. 91-05362)

TEAMSTERS LOCAL 11 BENEFIT FUND; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; KATLUSKA BAIDAL; WILLIAM BARTELL; GUNTER BLOHM; ANGELO BUINNO; BETTY J. CAIRNS; FRANK CLOSE; JOSE CRUZ; SANTOS GARCIA; KAREN GENSURE; DOROTHY LARSON; RICHARD LITCHFIELD; SANDRA MARINO; JOHN MATUSZKIEWICZ; GEORGE MCCLAUGHLIN; OLGA MONTES; FERNANDO PEREZ; SANTO RAMOS; MARTHA SARA; ROXEEN SCALA; EDMUND SCOTT; CHARLIE TAYLOR; MELISSA TURI; SANGPO TSULDIN; COSMO VISENTINI

v.

BAYSHORE COMMUNITY HOSPITAL; CHILTON MEMORIAL HOSPITAL; CLARA MAASS MEDICAL CENTER; DOVER GENERAL HOSPITAL; ELIZABETH GENERAL MEDICAL CENTER; ENGLEWOOD HOSPITAL; HOLY NAME HOSPITAL; IRVINGTON GENERAL HOSPITAL; JERSEY CITY MEDICAL CENTER; PASSAIC GENERAL HOSPITAL; ST. FRANCIS HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; UNION HOSPITAL; UNITED HOSPITAL; UNIVERSITY HOSPITAL; VALLEY HOSPITAL; WARREN HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 92-00085)

TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475; WILLIE A. BARNES; HERMAN GEIGER; VINSTON LEE KING; KEVIN E. KLINE; ROBERT L. ROSA; WILLIAM BRENNAN; JAMES MURPHY, JR.; PATRICIA MCELLIGOTT; KEVIN MCCORMICK; PATRICK RYAN, JR.;

ANTHONY E. SMITH; ROBERT LAVERATT; JOHN S. WITTEK; JOHN MCQUILKEN; JOHN MONTESANO; ROY E. FRANK; JOHN O'NEILL, JR.; FRANK ROBINSON; DALE SCHAEFER; JOHN J. SERRA; DONALD SHERIDAN; WENCESLAO SOTO; MICHAEL J. RUSSO; JOSEPH P. MURPHY, JR.; CALVIN R. SUTTON, III; RONALD J. ZAKARZEWSKI; FRANK WHITNEY, SR.; JACK NACHTIGALL; LAWRENCE PARKIN; EDISON RODRIGUEZ; WILLIAM MORAN; VINCENT DOFFONT

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; WEST HUDSON HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY; OVERLOOK HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; UNION HOSPITAL; RIVERVIEW MEDICAL CENTER; NORTHERN OCEAN HOSPITAL SYSTEM; COMMUNITY MEDICAL CENTER; HOSPITAL CENTER AT ORANGE; HUNTERDON MEDICAL CENTER; WARREN HOSPITAL; CENTRASTATE MEDICAL CENTER; SOMERSET MEDICAL CENTER; ROBERT WOOD JOHNSON UNIVERSITY; THE MEDICAL CENTER OF OCEAN COUNTY; JERSEY SHORE MEDICAL CENTER; COLUMBUS HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER

(Newark New Jersey District Civil No. 92-00426)

TEAMSTERS LOCAL 641 WELFARE FUND; CARLOS ROCHA; GEORGE KOESTER; CARMELA FERENS; KHOONRAJIE RAGHUBANS; PHILLIP SAVITTIERI; EARL PATTERSON; ROBERT REEDER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; MEDICAL CENTER OF OCEAN COUNTY; ST. BARNABAS MEDICAL CENTER; CLARA MAASS

MEDICAL CENTER; ST. ELIZABETH HOSPITAL; PASSAIC GENERAL HOSPITAL

(Newark New Jersey District Civil No. 92-00526)

LOCAL 1245 HEALTH FUND; LOCAL 1245 BAKERY AND SPECIALTY HEALTH FUND; JAMES ARBOLINO; ANTHONY ROCCO; HAROLD POLSKY; NEVIO MANCIINI; WILLIE SCONIERS; IRENE HICKEY; KATHLEEN RODRIGUEZ; WILLIAM CLACKWORTHY; EDWARD NELSON; PATRICIA CONRAD; RONALD COZZO; HOLLY ANN CULBERT; JOACHIM SCHAFFRANIETZ; HUBERT CHASE; ROBERT BAUMAN; RUSSELL SCHWARTZ; JEAN JACQUES KERVAN; ARTHUR BEYER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; DOVER GENERAL HOSPITAL; THE MEDICAL CENTER OF OCEAN COUNTY; SAINT BARNABAS MEDICAL CENTER; UNION HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; ENGLEWOOD HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; CENTRASTATE; SAINT PETER'S MEDICAL CENTER; SAINT MARY'S HOSPITAL; MEADOWLANDS HOSPITAL AND MEDICAL CENTER; JERSEY SHORE MEDICAL CENTER; KENNEDY MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL

(Newark New Jersey District Civil No. 92-00728)

ANTHONY RIZZO; JOSEPH ABBATE; JOSEPH MASSOUD; RALPH MASTRANGELO, as Trustees of the Local 945, I.B.T. Welfare Fund

v.

BARNERT MEMORIAL HOSPITAL CENTER; BAYONNE HOSPITAL; BAYSHORE COMMUNITY HOSPITAL; BERGEN PINES COUNTY HOSPITAL; CENTRASTATE MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; CHRIST HOSPITAL; CLARA MAASS MEDICAL CENTER; COLUMBUS HOSPITAL; COMMUNITY MEMORIAL HOSPITAL; DOVER GENERAL HOSPITAL & MEDICAL

CENTER; ELIZABETH GENERAL MEDICAL CENTER; GREENVILLE HOSPITAL; HACKETTSTOWN COMMUNITY HOSPITAL, HOLY NAME HOSPITAL; IRVINGTON GENERAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; KENNEDY MEMORIAL HOSPITALS AT SADDLE BROOK; KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; MONTCLAIR COMMUNITY (HOSPITAL); MORRISTOWN MEMORIAL HOSPITAL; NEWTON MEMORIAL HOSPITAL; OVERLOOK HOSPITAL; PALISADES GENERAL HOSPITAL, PASCACK VALLEY HOSPITAL; PASSAIC BETH ISRAEL HOSPITAL; RAHWAY HOSPITAL; RARITAN BAY MEDICAL CENTER/PERTH AMBOY DIVISION; RIVERVIEW MEDICAL CENTER; ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; SOUTHERN OCEAN COUNTY HOSPITAL; ST. MARY'S HOSPITAL (PASSAIC); ST. JOSEPH'S HOSPITAL & MEDICAL CENTER; ST. FRANCIS MEDICAL CENTER; ST. ELIZABETH HOSPITAL; ST. PETER'S MEDICAL CENTER; THE GENERAL HOSPITAL CENTER AT PASSAIC; UNION HOSPITAL; UNIVERSITY HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; VALLEY HOSPITAL; WALLKILL VALLEY HOSPITAL AND HEALTH CENTERS; WARREN HOSPITAL; WAYNE GENERAL HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 92-00849)

NEWCOMB MEDICAL CENTER

v.

JENNIS CARPENTER; ALICE CARPENTER, his wife, jointly, severally and in the alternative

Defendants/Third Party Plaintiffs

v.

FRANCES J. DUNSTON; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF

MEDICAL ASSISTANCE AND HEALTH SERVICES
Third Party Defendants

(Newark New Jersey District Civil No. 92-01282)

NEWCOMB MEDICAL CENTER

v.

SHANA TRIPP; CHARLES TRIPP, jointly, severally and in the alternative

Defendants/Third Party Plaintiffs

v.

NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health

Third Party Defendants

(Newark New Jerseys District Civil No. 92-01454)

NEWCOMB MEDICAL CENTER

v.

FRED KUEKEN
Defendant/Third Party Plaintiff

v.

FRANCES J. DUNSTON; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
Third Party Defendants

(Newark New Jersey District Civil No. 92-01455)

New Jersey Hospital Association; Bayshore Community Hospital; Monmouth Medical Center; Pascack Valley Hospital; Riverview Medical Center; Kennedy Memorial Hospitals at Saddle Brook, Inc.; William B. Kessler Memorial Hospital; St. Francis Hospital;

South Jersey Hospital System; Helene Fuld Medical Center; Newton Memorial Hospital; The Medical Center of Ocean County; Bayonne Hospital; Kennedy Memorial Hospitals-University Medical Center; South Amboy Memorial Hospital; Underwood Memorial Hospital; Muhlenberg Regional Medical Center; Englewood Hospital; Zurbrugg Memorial Hospital; St. Mary Hospital; Community Medical Center; Hunterdon Medical Center; St. Michael's Medical Center; The Mercer Medical Center; St. Peter's Medical Center; Jersey Shore Medical Center; Irvington General Hospital; John F. Kennedy Hospital; Our Lady of Lourdes Medical Center; Overlook Hospital; Raritan Bay Medical Center; St. Elizabeth Hospital; Wayne General Hospital; Barnert Hospital; Atlantic City Medical Center; Dover General Hospital & Medical Center; Holy Name Hospital; The Hospital at Orange; St. Clare's/Riverside Medical Center; Clara Maas Medical Center; Deborah Heart & Lung Center; Rahway Hospital; West Jersey Health System; Hackensack Medical Center; Newark Beth-Israel Medical Center; St. James Hospital; St. Joseph's Hospital & Medical Center; Christ Hospital; Chilton Memorial Hospital; East Orange General Hospital; Columbus Hospital; Cooper Hospital/University Medical Center; Memorial Hospital of Burlington County Memorial Health Alliance; Medical Center at Princeton; St. Joseph's Hospital; Shore Memorial Hospital; Robert Wood Johnson University Hospital; Burdette Tomlin Memorial Hospital; Somerset Medical Center; Mountainside Hospital; Union Hospital; United Hospitals Medical Center at Passaic; and Morristown Memorial Hospital,

Appellants

On Appeal From the United States District Court For the District of New Jersey

(D.C. Civil Action Nos. 90-02639, 90-03640, 91-00073, 91-00336, 91-02190, 91-03280, 91-03286, 91-03897, 91-03910, 91-04078, 91-04259, 91-04700, 91-05362, 92-00085, 92-00426, 92-00526, 92-00728, 92-00849, 92-01282, 92-01454, 92-01455)

Argued September 18, 1992

BEFORE: STAPLETON, SCIRICA, and NYGAARD, *Circuit Judges*

(Opinion Filed May 14, 1993)

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OPINION OF THE COURT

STAPLETON, *Circuit Judge:*

Appellees, several self-insured employee benefit plans and a number of individual participants in those plans ("the plans"), brought this action seeking an injunction against the application to them of New Jersey's then current statutory scheme for setting hospital rates. They also sought restitution of monies paid under protest pursuant to that statutory scheme. Appellees argue both that the New Jersey statute was preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 *et seq.*, as amended ("ERISA"), and that the statute worked an unconstitutional taking of property without just compensation. Appellants are numerous New Jersey hospitals, various agencies and officials of the state of New Jersey and, as an intervening party, the New Jersey Hospital Association ("the defendants").

The district court entered summary judgment in favor of the plans on their ERISA preemption claim and enjoined the enforcement of the statute as it applied to them. The injunction was stayed, pending this appeal. The district court also entered summary judgment in favor of the defendants on the plans' constitutional claims, and declined to reach the question of restitution. The defendants appeal, and the plans cross-appeal.

We will reverse the summary judgment on the ERISA preemption claim and vacate the injunction. We will affirm the summary judgment on the constitutional claims, and remand the case to the district court with instructions that judgment be entered for the defendants.

I.

The statutory and regulatory regime in question is found in the New Jersey Health Care Facilities Planning Act of 1971, as amended by the Health Care Cost Reduction Act of 1978, N.J. Stat. Ann. 26:2H-1 *et seq,* (both shall be collectively referred to as "Act") and the attending regulations. N.J. Admin. Code 8:31B *et seq.*

In 1978, New Jersey enacted a revised rate setting system. Chapter 83, the dual purpose of which was to "contain the rising costs of health care services, and to ensure the financial solvency of hospitals." N.J. Stat. Ann. 26:2H-1. Under this prospective rate-setting system, various medical procedures are divided into "diagnostic related groups" ("DRGs"), and a rate is assigned to each DRG. A particular hospital's DRG rate consists of a weighted average of the costs incurred by the hospital in treating a given condition and the average cost incurred by hospitals throughout the state to treat that condition. The system thus penalizes hospitals that incur costs greater than the state wide average and rewards hospitals that provide more efficient service for a particular DRG. Patients in the same DRG at a particular hospital pay the same bill regardless of the duration of their stays and the demands they make on the resources of the hospital.

The DRG rate is the base rate under New Jersey's system. A patient's bill will have other components, and it is these components that the plans challenge as inconsistent with ERISA. Hospitals in New Jersey are required by law to provide treatment for patients who cannot pay their bills. N.J. Admin. Code 8:436-5.2(c). Emergency services for the indigent are required by federal law as well. Thus, one cost of doing business for New Jersey hospitals is the cost of providing "uncompensated care." In order to pay for this care and to provide financial relief to those hospitals that provide more than their share of uncompensated care, a state wide charge is added to the DRG, and the resulting revenue is distributed in proportion to the uncompensated care provided by each hospital.

An additional surcharge is designed to compensate hospitals for the losses they incur when treating patients covered by Medicare. Hospitals that treat Medicare patients can charge those patients only the amount allotted by the federal Medicare agency for the particular treatment provided. Medicare now provides reimbursement at levels below the DRG rates. To enable New Jersey hospitals to make up for the resulting revenue shortfall, the current New Jersey

system allows hospitals to include in their billings to non-Medicare patients an amount necessary to recover the difference between the Medicare rate of payment and the DRG rate.

Chapter 83 also grants discounts to certain classes of payors. The relevant section provides in part:

> All payment rates shall be equitable for each payor or class of payors without discrimination or individual preference except for quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole. In addition to other such benefits which the commission may consider, it shall consider the following, if found to be quantifiable: (1) degree of promptness and volume of payments to hospitals so that hospitals are provided with funds for current financing of their services, and (2) broad provision of health insurance coverages which are not self-supporting. In determining the quantifiable economic benefits to which consideration shall be given in approving payment rates, the commission may consider overall financial benefits to society which are provided by programs offered by a payor or class of payors.

26:2H-18b N.J. Stat. Ann. Pursuant to this provision, the commission granted a 2.2% discount to high-volume plans such as Blue Cross and granted an 11% discount to plans with open enrollment. Patients who do not belong to plans that received these discounts are billed at an increased rate to allow hospitals to recover the income lost by virtue of the discount. One of the plaintiff plans has applied for a discount under this portion of Chapter 83, but the commission has not yet ruled on its application.[1]

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[1] Individuals and third party payors can challenge a bill, through appeal, for such things as an alleged incorrect assignment of a DRG. Only an uninsured individual whose DRG bill exceeds his or her itemized medical costs by $250 may appeal "in exceptional cases of DRG assignments which, although technically correct, may produce grossly inequitable or excessive payments . . . . Upon demonstration, by substantial evidence, that application of the DRG system would result in inequitable consequences for the patient, the qualified utilization review organization may direct that payment be based on an alternative to the DRG rate (for example, charges)." N.J. Admin. Code 8:31B-3.78(a)viii. Unlike the surcharges to offset the costs of indigent care, Medicare, and payor discounts, the provision of Chapter 83 that allows some uninsured individuals to reduce their bills does not result in a specific surcharge that is added to the bills of other paying customers. This equitable over-ride for some uninsured individuals does not single out participants in ERISA plans for special treatment. It is not available to any individual who is entitled to reimbursement of medical expenses from any third party payor.

II.

At the threshold of our consideration we must determine whether this case is moot. The regulatory scheme we have just described was superseded by new state legislation on January 1, 1993. As we have noted, however, the plans seek not only an injunction against enforcement of the (now superseded) Act, but also restitution of monies paid by appellees pursuant to the Act while it was in effect. If the Act is infirm for either of the reasons asserted, the claim of restitution remains viable even though an injunction is no longer necessary. In order to adjudicate the merits of the restitution claim, we must determine if the monies were paid pursuant to an unlawful statutory scheme.[2] We thus turn our attention to an evaluation of the lawfulness of the Act.

III.

For the reasons set forth by the district court in its opinion, we find that the extra costs paid by the plans pursuant to the Act do not constitute an unlawful taking of property without just compensation. See, *United Wire, Health & Welfare Fund v. Morristown*, 794 F. Supp. 524, 540-42 (D.N.J. 1992).

In *Penn Central Transportation Co. v. New York City*, 438 U.S. 104 (1978), the Supreme Court utilized a three prong analysis to determine whether a governmental regulation constituted a taking. The *Penn Central* analysis directs our attention to (i) the character

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(Continued)

The record does not disclose how many uninsured individuals have filed appeals under the equitable over-ride provision, and we find no record basis for the suggestion that the "transparent goal ... of this appeal process" is to impose "the lion's share of [the cost of caring] for the uninsured" on New Jersey's ERISA plans. Dissenting Op., pp. 39, 41.

[2] The plans assert that 29 U.S.C. § 1132(a) and federal common law give them a right to recover the amounts they have paid to the hospitals under protest. The district court did not expressly determine whether § 1132(a) or the federal common law provided a right to restitution under the circumstances of this case. Its opinion, however, states that it "declines to exercise its pendent and supplemental jurisdiction over plaintiffs' restitution claims," 793 F.Supp. at 542, perhaps indicating that the district court may have viewed state law as providing the plaintiffs' only possible remedy. In view of our ultimate conclusion that chapter 83 is not preempted, we have no occasion to reach this issue. It is sufficient for our purposes to note that a case or controversy remains between the parties; the preemption issue is not moot because the plaintiffs make a claim for restitution, and an essential element of that claim is that ERISA's preemption provision has been violated.

of the governmental action; (ii) the economic impact of the regulation on the claimant; and (iii) the extent to which the regulation has interfered with investment backed expectations. *Penn Central* at 124. Regarding the character of the government action, we conclude that New Jersey "does not physically invade or permanently appropriate any of the [plan's] assets for its own use," but rather "adjusts the benefits and burdens of economic life to promote the common good". *Connolly v. Pension Guaranty Corp.*, 475 U.S. 211, 225 (1986). Similarly, the economic impact of the Act upon the appellees indicates that no taking has occurred. While appellees have been deprived of money by operation of the Act, the determination of the amount owed was not randomly generated, but was rather "directly related to the individual [appellee's] hospital bill." *United Wire*, 793 F.Supp. at 542. Finally, given the historically heavy and constant regulation of health care in New Jersey, we cannot say that the Act interfered with the plans' "investment backed expectations." We thus affirm the district court's summary judgment for the defendants on the constitutional claim.

IV.

Whether the Act is preempted by ERISA is a somewhat thornier question. Section 514(a) of ERISA provides that, with some exceptions that do not apply in this case, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. It is undisputed that the plans are covered by ERISA, and so the question to be determined is whether the Act "relate[s] to" the plans in a way that necessitates preemption. We find that the Act does not relate to the plans in a way that triggers ERISA's preemption clause.

The preemption clause of ERISA is notable for its breadth, and manifests Congress's intention to establish pension plan regulation as an exclusively federal concern. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). The Supreme Court has noted that a state law "relates to" an ERISA governed plan, within the meaning of § 514(a)'s preemptive reach, "if it has a connection with or reference to such a plan." *Shaw v. Delta Airlines*, 463 U.S. 85, 97 (1983). The Court in *Shaw* noted, however, that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law "relates to" the plan. 463 U.S. at 100, n. 21.

In determining whether the New Jersey scheme of regulating hospital rates is preempted by ERISA, "as in any preemption analysis, 'the purpose of Congress is the ultimate touchstone.' " *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)). The Supreme Court discussed at length the Congressional intent behind the ERISA preemption clause in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987). In *Fort Halifax* the Court was faced with the question of whether ERISA preempted a Maine statute requiring employers, in the event of a plant closing, to provide a one-time severance payment to employees not covered by an express contract providing for severance pay. In the course of holding that the Maine statute was not preempted, the Court explained the Congressional intent behind ERISA's preemption clause:

> [A]n employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payment, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.
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> It is thus clear that ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption

> ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Fort Halifax, 482 U.S. at 9, 11. It is with this Congressional purpose in mind that one must read the myriad of ERISA preemption cases that have been decided in the courts since ERISA was adopted. It informs the following analysis of these cases.

A rule of law relates to an ERISA plan if it is specifically designed to affect employee benefit plans,[3] if it singles out such plans for special treatment,[4] or if the rights or restrictions it creates are predicated on the existence of such a plan.[5] Because we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans, the cases which have cordoned off this area of preemption are inapplicable.[6]

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[3] *See, e.g., Bricklayers Local 33 v. America's Marble Source*, 950 F.2d 114 (3d Cir. 1991) (ERISA preempts a New Jersey statute that regulates the payment of fringe benefits); *McMahon v. McDowell*, 794 F.2d 100 (3d Cir. 1986) (ERISA preempts a Pennsylvania statute that allowed employees to collect unpaid ERISA plan benefits directly from the officers of a company, thus adding to the employee plans another means of collecting benefits), *cert. denied*, 479 U.S. 971 (1986).

[4] *See, e.g., Mackey v. Lanier Collection Agency and Service, Inc.*, 486 U.S. 825 (1988) (a portion of Georgia's garnishment statute "which singles out ERISA plan, by express reference, for special treatment is preempted." *Id.*, at 838, n. 12: *McCoy v. Massachusetts Institute of Technology*, 950 F.2d 13, 19 (1st Cir. 1991) (ERISA preempts a Massachusetts lien statute which "expressly singles out ERISA plans for special treatment."), *cert. denied*, 112 S.Ct. 1939 (1992).

[5] *E.g., District of Columbia v. Greater Washington Bd. of Trade*, 113 S.Ct. 580 (1992) (ERISA preempts a District of Columbia statute that required employers who provide health insurance for their employees to provide equivalent health insurance coverage for injured employees eligible for workers' compensation benefits); *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990) (ERISA preempts employee's state law wrongful discharge claim where claim was based on allegation that discharge was motivated by employer's desire to avoid making contributions to employee's pension fund).

[6] As the plans correctly point out, the Supreme Court has declared that the phrase "relates to" in § 514(a) is used "in the normal sense of the phrase" and has cited the definition of "Relate" found in Black's Law Dictionary. That definition includes "to refer to" as one accepted meaning. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, n. 16 (1983). Nevertheless, we disagree with the plans' argument that Chapter 83 is preempted simply because it expressly refers to "self-funded union" plans as one example of a "third party payor". Where, as here, a reference to an ERISA plan can be excised without altering the legal effect of a statute in any way, we believe the reference should be regarded as without legal consequence for § 514(a) purposes. Thus, for example, a state statute providing that "no employer, including an ERISA plan, shall discriminate on grounds of race or gender" would not be preempted despite its reference to an ERISA plan. See footnote 11 *infra*.

This does not end our inquiry, however. A state rule of law may be preempted even though it has no such direct nexus with ERISA plans if its effect is to dictate or restrict the choices of ERISA plans with regard to their benefits, structure, reporting and administration, or if allowing states to have such rules would impair the ability of a plan to function simultaneously in a number of states.[7]

New Jersey's scheme may increase the charges billed to ERISA plan participants for hospital services. This will mean that for any plan which commits to pay all or some lesser percentage of a participant's hospital costs will be called upon to pay more in benefits than it otherwise would. This effect is no different in kind, however, from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, i.e., utility costs, the wages of its employees, waste disposal costs, etc. New Jersey's scheme does not direct ERISA plans to structure their

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We also disagree with the dissenting opinion's suggestion that a statute should be preempted solely because the participation of ERISA plans is required as a matter of economics in order for the statute to meet its social goals. This is not what we understand the Supreme Court to have meant in *Greater Washington Board of Trade* when it held that statutes predicated on the existence of ERISA plans "relate to" such plans. The statute in that case could not be applied without reference to the "coverage levels set forth in ERISA plans." As we understand it, it is of no legal consequence if removing ERISA plans from the scene would diminish the likelihood that the statute would meet its social goals. Rather, the test for preemption in this regard is whether the existence of ERISA plans is necessary for the statute to be meaningfully applied. *Greater Washington Board of Trade,* 113 S.Ct. at 583-84.

[7] *See, e.g., FMC Corp. v. Holiday*, 111 S.Ct. 403, 408 (1990) (ERISA preempts a Pennsylvania antisubrogation statute which prevented Pennsylvania plans "from being structured in a manner requiring reimbursement in the event of recovery from a third party"); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (ERISA preempts New Jersey statute insofar as that statute prevents ERISA plans from decreasing benefits by the amount a recipient is awarded in worker's compensation subsequent to retirement); *Hampton Industries Inc. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992); (ERISA preempts a North Carolina antisubrogation statute); *National Elevator Industry, Inc. v. Calhoun*, 957 F.2d 1555, 1561 (10th Cir. 1992) (ERISA preempts administrative interpretation of Oklahoma's prevailing wage statute insofar as it determines rates of pay and "may be used to effect change in the administration, structure and benefits of an ERISA plan"), *cert. denied*, 113 S.Ct. 406; *Michigan Carpenters Council v. C. J. Rogers, Inc.*, 933 F.2d 376 (6th Cir. 1991) (ERISA preempts Michigan state corporate reorganization statute that allows employers unilaterally to alter their obligation to ERISA plans), *cert. denied*, 112 S.Ct. 585 (1991); *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital*, 947 F.2d 1341 (8th Cir. 1991) (ERISA preempts Arkansas statute regulating the assignment of benefits to health care providers), *cert. denied*, 112 S.Ct. 2305 (1992).

benefits or conduct their internal affairs in any particular way. Nor does it deprive ERISA plans of any alternative they would otherwise have in these areas. Finally, since the cost of hospital services will necessarily vary from region to region, we fail to see how state regulation of hospital pricing like that chosen by New Jersey is likely to make interstate operation of an ERISA plan more difficult.

Where there is no direct nexus between a state statute and ERISA plans, no effect on the manner of such plans' conducting business or their ability to operate in interstate commerce, statutes have been upheld despite the fact that they may have the indirect ultimate effect of increasing plan costs. In *Mackey v. Lanier Collection Agency and Service, Inc.*, 486 U.S. 825 (1988), for example, the court held that Georgia's general statute authorizing garnishment of obligations due debtors could be utilized by creditors of ERISA plan participants to require the application of plan benefits to satisfy participants' personal debts. Georgia garnishment law as so applied was found not to be preempted by § 514(a) despite the fact that "benefit plans subjected to garnishment . . . incur substantial administrative burdens and costs" in responding to garnishment summons.

The most helpful case in the present context is *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), where the court sustained against a preemption challenge a New York statute setting the rates that hospitals in that state had to charge patients, including those who were participants in self-insured employee benefit plans. The court, after noting the obvious "fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted § 514," made the following observations that seem equally pertinent here:

> A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction.
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> The purchase of hospital service is like the purchase of public utility service, or of any other service or commodity whose price is controlled by the State. Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine

> what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees. In short, if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress. Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.
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> Moreover, such indirect economic impact as may result from State control over hospital rates does not run counter to ERISA's aim of national uniformity in plan regulation. *See Shaw v. Delta Air Lines, Inc.*, *supra*, 103 S.Ct. at 2890 n. 20. There is no valid reason why employee benefit plans cannot be subject to nationally uniform supervision despite dissimilarities in their costs of doing business. Indeed, if statutes such as section 2807-a(6)(b) of New York's Public Health Law are held to be preempted by ERISA, every hospital will be able to set its own rates for ERISA plans, and appellee does not contend that these rates are, or will be, uniform, even as between hospitals in the same locality.

749 F.2d at 138-9.

The plans insist that *Rebaldo* is no longer "good law" in light of the Supreme Court's subsequent decision in *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990). While we agree that a portion of the *Rebaldo* court's analysis was rejected in *Ingersoll-Rand*, the above-quoted reasoning remains persuasive and we are confident that *Rebaldo* would have been decided in the same way if the court had had the benefit of the teachings of *Ingersoll-Rand*.[8]

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[8] We thus find ourselves unpersuaded by the Southern District of New York's recent opinion in *Travelers Insurance Co. v. Cuomo*, 813 F. Supp. 996, which suggested that *Rebaldo* has been entirely eroded by opinions of the Supreme Court. The opinion proceeds from what appears to us to be a misconstruction of the Supreme Court's opinion in *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990). The court in that case seems to understand FMC to have been concerned with presenting uniform costs of doing business to plan administrators. By our reading, however, FMC was concerned to prevent a state statute from forcing decisions regarding the internal design and structure of benefit plans (e.g. who may collect, and how, and from whom).

In *Ingersoll-Rand*, the Supreme Court addressed the issue of whether § 514(a) preempts a state cause of action in favor of an employee terminated to prevent the vesting of his or her pension benefits. It was confronted with an argument that the phrase "relate to any employment benefit plan" should be read in the context of § 514 as a whole and that the wording of §514(c)(2) indicates that § 514 preempts only a state law which "purports to regulate, . . . directly or indirectly, the terms and conditions of employee benefits plans." 29 U.S.C. §1144(c)(2).[9] If § 514(c)(2) did so limit the scope of § 514, the state cause of action at issue would not be preempted because it did not purport to regulate the terms and conditions of ERISA plans. The Supreme Court determined, however, that §514 preemption was not so limited and that it extended to a state cause of action predicated on the existence of an employee benefit plan. Since one of the elements of the state cause of action was the existence of such a plan, the Supreme Court had "no difficulty in concluding" that it was preempted. *Id.* at 483. It explained,

> . . . We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan. Nor is the cost of defending this lawsuit a mere administrative burden. Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension *plan* itself.

While the court in *Rebaldo* did suggest that § 514(c)(2) could be read to limit the scope of § 514 preemption,[10] this was not the touchstone of its analysis. Unlike the court in *Ingersoll-Rand*, the *Rebaldo* court *was* "dealing ... with a generally applicable statute that makes no reference to, [and] functions irrespective of, the existence of an ERISA plan." *Id.* at 483, and that affects such plans only by increasing their costs of doing business. As the above-quoted portions of the opinion bear witness, it was the absence of a direct nexus to ERISA plans and the limited nature of the statute's impact on such plans that put the pricing regulation in *Rebaldo* beyond the scope of § 514 preemption.[11]

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[9] Section 514(c)(2) reads in full:

> The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly

In summary, we, too, have before us a generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state. We have found no case that has held such a law to be preempted by § 514(a), and we decline to so hold.

As we analyze the issue before us, we are not troubled, as was the district court, by what the plans refer to as the cost shifting aspects of New Jersey's program. The district court accepted the plans' argument that New Jersey was requiring them to act in a manner inconsistent with their obligation under ERISA to apply fund assets only for the benefit of fund participants. Were this the case, New Jersey's statute would, of course, be preempted as applied to the plans. But plaintiffs purport to understand ERISA to impose upon them a burden which would be an intolerable one and which we are confident Congress never intended ERISA plans to bear.

The plans argue that their fiduciary duty to apply fund assets only for the benefit of fund beneficiaries forbids them from paying for hospital services received by those beneficiaries if any portion of the price paid can be viewed as attributable to the cost of providing services to others, such as indigent and Medicare patients. As

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(Continued)

> or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

29 U.S.C. § 1144(c)(2).

[10] The infirmity of this portion of the *Rebaldo* opinion is noted by the Court of Appeals for the Second Circuit in *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 n. 3 (2d Cir. 1992).

[11] The reasoning of the court in *Rebaldo* parallels that in *Lane v. Goren*, 743 F.2d 1337 (9th Cir. 1984) which held that the application of California's anti-discrimination laws to the employment practices of an ERISA plan's trustees is not preempted by ERISA. The court so held because the California law affected the trustees only in their "capacity as an employer, and in a way that all other employers were affected," *Id.* at 1340, because the only effect was to increase the trustee's costs of doing business. The court noted:

> That argument does not withstand scrutiny. So too, for example, do state law and municipal ordinances regulating zoning, health, and safety increase the operational costs of ERISA trusts, but no one could seriously argue that they are preempted.

See, also, Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97 n. 17 (1983) (New York's anti-discrimination law as applied to ERISA plans is not preempted "insofar as it prohibits employment discrimination in hiring, promotion, salary, and the like").

the plans appear to us to concede, however, it would be impossible to have a requirement that ERISA plans must "look through" to the pricing structure of every health care provider to assure that the price of the services rendered a particular patient directly correlates with the costs of those services. We think an ERISA plan meets its ERISA responsibilities when it pays whatever portion of the price charged by the health care provider the plan has assumed.

First, the plans do not challenge the base DRG rate feature of New Jersey's price control program even though it is inherent in this approach that a patient having an appendectomy who winds up in intensive care for two weeks pays the same amount as another patient who has an appendectomy and leaves the hospital the following day. The plans do not challenge this aspect of the plan because they acknowledge that it is not feasible in any real sense to isolate the costs attributable to any particular patient. The plans understandably add that if they have enough appendectomy patients over the years the costs they pay on behalf of others theoretically will be offset by the costs other pay on behalf of plan participants. It nevertheless remains true that the portions of the New Jersey scheme unchallenged by the plans recognize the prohibitive transactions costs associated with matching any particular disbursement of fund assets to cover a hospital bill with the actual costs of treating that particular patient.

More importantly, there are many forms of state regulation under the police power which result in increases in the cost of doing business and corresponding increases in prices where the beneficiaries of the regulation are not those who are paying the increased prices. States have recently begun to regulate the disposal of medical wastes, for example, in order to protect those who otherwise would be adversely affected by socially irresponsible disposal. Such regulations can significantly increase a hospital's cost of doing business and, accordingly, its billings to plan participants. We are confident, however, that ERISA was not intended to foreclose a state regulation of this kind. New Jersey's decisions to require hospitals to treat indigents and to treat Medicare patients for the Medicare reimbursement seem to us to be similar exercises of its police power.

In short, we are unwilling to attribute to Congress and §514 an intent to frustrate the efforts of a state, under its police power, to regulate health care costs. In particular, we are unwilling to infer

from ERISA's prohibition against applying fund assets for the benefit of others a Congressional intent to foreclose health care cost regulation of the kind here challenged.

V.

Having concluded that the challenged portions of Chapter 83 are not preempted by § 514(a) and are not unconstitutional, we will reverse the judgment of the district court, vacate the injunction, and remand with instructions that judgment be entered for the defendants.[12]

NYGAARD, *Circuit Judge*, dissenting.

This is a close case because it tests the outer limits of ERISA preemption. Although my decision is made more difficult because the New Jersey regulatory scheme (the "Act") is admirable for its intended purpose and goals, I think Congress intended to preempt these kinds of statutes. The issue is: Whether a statute of purported general applicability "relates to," in the ordinary and broad sense of that term, ERISA plans if it disproportionately impacts upon ERISA plans, presupposes the existence of ERISA plans, and depends on funds extracted from ERISA plans to implement its legislative mandate. Because I believe that the district court correctly concluded that such a statute is preempted, see *United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hosp.*, 793 F.Supp. 524, 531-37 (D.N.J. 1992), I respectfully dissent.

I.

Congress enacted ERISA to subject employee benefit plans to a uniform system of federal laws governing disclosure, reporting, standards of conduct, remedies, sanctions, and access to federal courts. Since uniformity cannot be achieved if ERISA plans are subject to varying state regulations, Congress preempted "any and all State laws insofar as they . . . *relate to* any employee benefit plans." ERISA § 514(a), 29 U.S.C. § 1144(a) (emphasis added).

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[12] It appears that there are plaintiff plans which have not asserted a claim for restitution. As to any such plaintiff, the passage of the new statute rendered its case moot. The district court should dismiss the claims of any such plaintiffs before entering judgment for the defendants on the remaining claims.

Section 514(a) is deliberately expansive and "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct. 403, 407 (1990). It is "virtually unique" among federal preemption statutes, *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26, 103 S.Ct. 2841, 2854 n.26, as it is "one of the broadest preemption clauses ever enacted by Congress." *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990).

The term "relate to" must be given a "broad common-sense meaning." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 1553 (1987). A state law relates to an ERISA plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 2900 (1983). Any connection may trigger preemption, and preemption is not limited to laws relating to the specific subjects covered by ERISA. *Pilot Life*, 481 U.S. at 47-48; *Shaw*, 103 S.Ct. at 2900. That a state law may be "consistent with ERISA's substantive requirements" or was enacted to "effectuate ERISA's underlying purposes" does not save it from preemption. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 2388-89 (1985); *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 108 S.Ct. 2182, 2185 (1988). A state law may relate to a benefit plan even if it is not specifically designed to affect such plans, or its effect is only indirect. *Pilot Life*, 107 S.Ct. at 1552-53; *Shaw*, 103 S.Ct. at 2900; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 1907 (1981); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 483 (1990).

Since no law exists in a vacuum and arguably many laws could be held to "relate to" ERISA plans, without some limits Section 514(a) could become a legal blackhole with an attractive force no state law could resist. Hence, some laws are said to affect ERISA plans in "too tenuous, remote, or peripheral a manner to warrant a finding that [they] relate to' the plan." *Shaw*, 103 S.Ct. at 2901 n.21. *See, e.g., Mackey*, 108 S.Ct. at 2191 (garnishment statute of general applicability is not preempted). The task then is to determine the precise relationship between the Act and ERISA plans. *Mackey*, 108 S.Ct. at 2186.

II.

The declared public policy of the Act is to "contain the rising costs of health care services, and to ensure the financial solvency of hospitals." N.J.S.A. § 26:2H-1. The linchpin in this scheme is the

DRG rate, which is a statistical average of costs incurred by hospitals to perform a particular medical procedure. The DRG is the rate hospitals must bill for particular services. Thus, it functions as both a price cap and an incentive to reduce costs.

The plans do not challenge the validity of the DRG rate scheme, but only attack three surcharge components incorporated into the DRG. They are costs for uncompensated care and bad debts. Medicare cost shifts, and costs related to discounts given to certain payer groups. Only hospital patients, not the general public, pay these costs. The New Jersey scheme is, quite simply, a cost-shifting mechanism whereby those who do not have deep pockets or are favored by the law are given discounts or free services. Since these discounts and services cause state-mandated financial losses to hospitals, the Act remunerates hospitals by shifting these losses through the DRG resulting in additional 19.7% and 7% surcharges in uncompensated and Medicare costs shifts to those with deep pockets — commercial insurers and ERISA plans.

ERISA plans play a critical role in this scheme, to the point where without them it would fall apart. They comprise a major segment of the paying hospital service users who subsidize those favored by the Act. The structure of the scheme indicates in not-so-subtle ways that the New Jersey legislature was well aware of the pivotal role ERISA plans would play in its scheme. Upon pain of not receiving reimbursements for their uncompensated care costs, the Act requires hospitals to screen patients to determine whether they are covered by a commercial insurer or a "union welfare plan." N.J.S.A. § 26:2H-18.31(c)(2). Also, under the appeal policy existing at the time, while individual patients as well as third-party payors could have appealed mistakes in the assignment of a particular DRG, only individual patients could have appealed an assignment of a DRG that was technically correct but may have been excessive. "The third-party payer (commercial insurer, *self-funded union*, etc.)" was specifically excluded from appealing a correct but excessive charge. A vast majority of appeals, about 85%, were based on excessive charges, and only about 1% of them were denied. Thus, the goal is transparent and little explanation is needed to see what this appeal process was designed to do.

In October 1990, the New Jersey Governor's Commission on Health Care Cost submitted a report that plainly concluded: "Only a portion of New Jersey businesses, those who purchase insurance for their workers, pay the lion's share of caring for the uninsured." It

summarized the impact on employee benefit plans: "It was apparent that rapidly rising health insurance costs were a significant burden to both the business community and the labor force in this State with the potential to negatively affect New Jersey citizens . . . that the Uncompensated Care Trust Fund while affording access to hospital services was unfairly financed on the backs of those who had health insurance . . . ."

Last, the State concedes that the scheme is not "viable"without money from the plans as they "represent a major segment of the bill-paying public, to the point that it is *impossible* to devise a viable hospital rate-setting scheme if that segment is excluded or exempted from the scheme." Br. 2 (emphasis added). This concession dispels any doubt that the effect of the Act is to reach into the deep pockets of ERISA funds.

The Act provides a conduit by which money is transferred from, among others, ERISA plans to hospitals. Rather than spend its own general funds, New Jersey implemented a money transfer scheme where ERISA plans subsidize the medical bills of those who are favored by law. One affidavit accurately concluded: "Indeed, if the State of New Jersey were to assume the uncompensated care and the Medicare cost shift as social obligations from its general revenues, for example, the average hospital bill would decrease on a pro rata basis by this amount and these shifts would no longer be reflected in New Jersey hospital bills."

III.

The majority believes that the connection between the Act and ERISA plans is too tenuous and remote "[b]ecause we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans . . . ."Majority typescript at 27. The majority relies in part on *Mackey v. Lanier Collection Agency & Serv., 108* S.Ct. 2182 (1988), to suggest that where there is no direct nexus, or where a statute does not directly affect the administration of ERISA plans, the statute is not preempted despite any "indirect ultimate effect of increasing plan costs." Majority typescript at 29.

In *Mackey* the issue was whether a generally applicable Georgia garnishment statute was preempted by ERISA. The Court first recognized that a statute need not specifically single out, mention, or

have a direct nexus to ERISA plans to be preempted. 108 S.Ct. at 2186, citing *Pilot Life*, 107 S.Ct. at 1552-53, and *Shaw*, 103 S.Ct. at 2900. The Court held, however, that the statute was not preempted. In light of certain ERISA provisions, one of which provides a plan may "sue or be sued" as an entity, 29 U.S.C. § 1132(d)(1), the Court reasoned that money judgments against ERISA plans must be collectable in some way and that garnishment is one permissible method. 108 S.Ct. at 2188 & n.9, citing *FHA v. Burr*, 309 U.S. 242, 60 S.Ct. 488, 491 (1940) (where Congress provides that an entity may "sue or be sued" all civil processes incident to legal proceedings including "garnishment and attachment" may apply). Thus, *Mackey* does not stand for the proposition that a generally applicable statute should not be preempted even though it may result in some "indirect economic impact." It stands for the proposition that where *Congress intended* for state law to apply to ERISA, that law will not be preempted even though it may otherwise relate to ERISA plans by placing indirect financial or administrative burdens on them.[1]

The majority nowhere shows how any provision in or the structure of ERISA suggests that Congress did not intend these kinds of statutes to be preempted. See *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978) ("purpose of Congress is the ultimate touchstone"). Where Congress adopts a broad preemption provision, the "task of discerning congressional intent is considerably simplified." *Ingersoll-Rand*, 111 S.Ct. at 482.

Although any connection may suffice, the task is made easier when the statute refers to or specifically singles out ERISA plans. The Act requires hospitals to ask patients whether they belong to a "union welfare plan," and it expressly excludes "self-funded union" plans from appealing hospital bills. The majority, however, brushes these references aside by concluding that they "can be excised without altering the effect of [the]statute in any way," and therefore they "should be regarded as without legal consequence for § 514(a) purposes." Majority typescript at 27 n.6.

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[1] Without the congressional intent derived specifically from the structure of ERISA, *Mackey* would probably have been decided differently. Both the majority and the dissent in *Mackey* observed that the garnishment law subjected the plans to "substantial" and "significant administrative burdens and costs." See 108 S.Ct. at 2186, 2192. Because "plans face the repetitious and costly burden of monitoring controversies involving hundreds of beneficiaries and participants in various States." *Id.* at 2193, Justices Kennedy, Blackmun, O'Conner, and Scalia dissented.

The majority underestimates the significance of these references. New Jersey has implicitly classified all hospital users into two groups: those who are able to pay and those who are not. This simple dichotomy then determines "whether the patient is eligible for participation in a public assistance program," N.J.S.A. § 26:2H-18-31(c)(3), whether one must pay the three surcharges, and whether and what one may appeal. A large segment of the small percentage of patients who are able to fully pay for medical services are plan beneficiaries, and hence New Jersey requires hospitals to ask whether a patient belongs to a "union welfare plan." Thus, the conclusion that the references to ERISA plans in the Act "can be excised without altering the effect of [the] statute in any way" is without support.

Even assuming, arguendo, that the Act does not expressly single out ERISA plans for special treatment, it does so *as applied*. One cannot ignore the practical consequences produced by this statute, a consequence that according to the report commissioned by the State resulted in ERISA plans having paid "the lion's share of caring for the uninsured." See *Mackey*, 108 S.Ct. at 2185 (it is "virtually taken [] for granted that state laws which are 'specifically designed to affect employee benefit plans' are pre-empted under § 514(a)").

Moreover, the assumption that the Act "functions without regard to the existence of such plans" is puzzling in light of the State's concession that the Act is not "viable" without ERISA plans. The Act was designed with ERISA funds in mind. In this sense, it has been eminently successful; the financial drain on ERISA funds has been enormous. The surcharges are paid not by the general public at large, but by the less than 25% of the population who use hospital services. Of those 25%, about 75% receive the uncompensated care assessments challenged here. ERISA plan participants comprise only about 15% of the hospital patients, but pay about 40% of the more than $1.1 billion shortfall generated by the state-mandated cost shifts.

In *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990), an employee sued in Texas state court, alleging that he was fired because his employer did not want to contribute to his pension fund. He sought damages under various tort and contract theories, but did not plead an ERISA cause of action. The Texas Supreme Court recognized a cause of action for wrongful discharge based upon "the employer's desire to avoid contributing to or paying benefits under the employee's pension fund." The Supreme Court reversed

and held that the cause of action is preempted because it was premised on the existence of a pension plan. It reasoned that "to prevail, a plaintiff must plead, and the court must find, that an ERISA plan exists and the employer had a pension-defeating motive in terminating the employment. Because the court's inquiry must be directed to the plan, this judicially created cause of action 'relates to' an ERISA plan." *Id.* at 483.

Similar to the Texas cause of action, the New Jersey statute is predicated on the existence of ERISA plans and its mandates cannot be carried out without ERISA funds. See *Id.* at 484 ("there simply is *no* cause of action if there is no plan") (emphasis in original). Also, the costs associated with the New Jersey regulatory scheme are not qualitatively the same as those in either *Mackey* or *Ingersoll-Rand*. In *Mackey*, the four dissenting Justices opined that the administrative burdens of allowing ERISA benefits to be garnished were so "significant" as to warrant preemption of a generally applicable garnishment statute. 108 S.Ct. at 2192. In *Ingersoll-Rand,* a unanimous Supreme Court noted that the litigation costs of defending against a cause of action predicated upon the existence of an ERISA plan were substantial. 111 S.Ct. at 483. No one will dispute that these costs pale in comparison to the hundreds of millions of dollars extracted from ERISA funds under the Act. And while the majority may classify these costs as "the limited nature of the statute's impact on such plans," I do not.

One may argue that nothing in the Act establishes the level of benefits or structure plan benefits to include these shifted costs and that each plan is free to cover all, some or none of these costs. This argument is unpersuasive. In *General Elec. Co. v. New York Dep't of Labor*, 891 F.2d 25 (2d Cir. 1989), a New York labor law of general application provided that wages and "supplements" (nonwage benefits which included ERISA plans) on a public works contract must at least equal the prevailing rate and benefits paid in the locality. Where the cost of a benefit provided by an ex-locality contractor did not match those of a similar prevailing local benefit, the statute required the contractor either to bring the benefit into conformity with the local benefit, or to make up the difference through cash payments to its employees. Nothing in the statute, however, required a contractor to alter the benefits to match those in the locality, and the contractor was free to pay cash instead. But the Court of Appeals for the Second Circuit held that ERISA preempted the labor law. It reasoned that the law clearly related to

ERISA plans in that to conform to the statute contractors had to maintain "schedules of supplements and wages and to make its books and records pertaining to wages, supplements and hours of labor available for inspection." *Id.* at 29-30.

The Act is analogous to the New York labor statute because it requires ERISA plans either to pay the surcharges or to restructure their benefits to avoid them. Since no one likes to pay for benefits or services one did not receive or benefit from, it is reasonable to expect that some plans may change their terms to exclude these costs, just as it was reasonable to expect that some New York contractors would restructure ERISA plans instead of paying cash benefits. Implicit, then, is the assumption that an ERISA plan, if it does not want to pay for the direct cost of services provided to nonbeneficiaries, "structure all its benefit payments in accordance with New Jersey [hospital rates], or to adopt different payment formulae for employees inside and outside of the State." See *Fort Halifax*, 107 S.Ct. at 2217; *Alessi*, 101 S.Ct. at 1907. This is the precise reason why Congress enacted such a broad preemption provision: so that employee benefit plans would not be subject to the vagaries of state regulations. *Ingersoll-Rand*, 111 S.Ct. at 484; *Fort Halifax*, 107 S.Ct. at 2217.

Because New Jersey has asked ERISA plans to carry the brunt of the burden of keeping hospitals financially afloat and, in fact, to largely subsidize its venture into hospital price regulation, and because the State admits that result before this court, I agree with the district court's conclusion that there is a definite, palpable connection between the Act and the plan. See *United Wire*, 793 F.Supp. at 531-37.

IV.

Much attention in this appeal has been focused on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984). The New York statute provided that the state must establish for each hospital an "inpatient revenue cap," which was a price cap with additional allowances made for bad debts and charity care. The statute allowed certain programs, like Blue Cross, to get discounts, but certain ERISA plans did not qualify. The Court of Appeals for the Second Circuit first reasoned that because Section 514(c)(2) defines "State" as any agency, instrumentality or political subdivision that "purports to

regulate, directly or indirectly, the terms and conditions of employee benefit plans." 29 U.S.C. § 1144(c)(2), this restriction modifies Section 514(a)'s broad preemption provision. 749 F.2d at 137. The court held that where "a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated." *Id.* at 139. This holding is now infirm as the Supreme Court has since rejected the view that the definition of "State" restricts the scope of Section 514(a). *Ingersoll-Rand*, 111 S.Ct. at 484.[2]

The *Rebaldo* court justified its holding with an economic/policy argument. It reasoned that the regulation of hospital rates are analogous to any state regulations that increase the cost of doing business for hospitals. 749 F.2d at 138. Thus, for example, the court opined that ERISA plans could not contend that they are exempt from price increases as a result of increased labor, utility, or rent costs, or from such minor costs as the bridge and tunnel tolls that are charged to plan officers or employees. *Id.* Moreover, it opined that since ERISA plans can be subject to nationally uniform supervision despite dissimilarities in hospital prices, any "indirect economic impact" would be consistent with ERISA's aim of national uniformity in plan regulation. *Id.* at 139.

Recently, even this economic rationale, for whatever worth it had, has been eroded. Although the *Rebaldo* court suggested that "State labor laws that govern working conditions and labor costs . . . that [have] some economic impact on the plan"would not be preempted, *id.* at 138-39, the Court of Appeals for the Second Circuit has since retreated from this position and has preempted a generally applicable statute governing labor costs that imposed upon ERISA plans indirect financial and administrative burdens. *General Electric*, 891 F.2d at 29-30.[3]

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[2] Although the majority recognizes that *Ingersoll-Rand* overruled *Rebaldo*, at least in part, it distinguishes *Ingersoll-Rand* on the basis that the *Rebaldo* court dealt with "'a generally applicable statute that makes no reference to, [and] functions irrespective of, the existence of an ERISA plan.'" Majority typescript at 32, quoting *Ingersoll-Rand*, 111 S.Ct. at 483. Of course, that is the question here.

[3] Indeed, although Judge Van Graafeiland authored both *Rebaldo* and *General Electric*, the dissent in *General Electric* considered *Rebaldo* controlling:

> The majority does not attempt to distinguish *Rebaldo* and *Aetna Life* nor, in my view, could it sensibly do so. Like the statutes we upheld in those decisions, New York's prevailing wage statute is a law of general application

Despite the Supreme Court's rejection of the holding in *Rebaldo* and the Court of Appeals for the Second Circuit's implicit rejection of what appears to be the rest, the majority nonetheless relies heavily on it. Faced with Section 514(a)'s sweeping preemption provision and the cause-and-effect financial connection between the Act and ERISA funds, the majority justifies its decision by reasoning that the Act is analogous to any number of state laws that may indirectly increase the cost of doing business, such as regulations governing labor, utility, or rent costs. Majority typescript at 29. It suggests as an example that regulations concerning the disposal of medical waste would not be preempted though their implementation may net higher medical bills as a result of the increased cost of doing business. *Id.* at 33.

I agree with the majority insofar as ERISA plans do not lead a "charmed existence." *Rebaldo*, 749 F.2d at 139. They are, of course, not exempt from paying rent, tolls, or even the many overhead costs associated with hospital management. The DRG takes into account both direct costs, such as hospital employees' salaries and benefits, and indirect costs, such as institutional overhead expenses for management, research, education and maintenance. The plans, however, do not argue that the *entire* DRG system is incompatible with ERISA; they do not argue that they must only pay the "actual costs" for medical services; they do not argue that any laws that increase the cost of doing business for hospitals do not apply to them; nor do they argue that they are entitled to pay to the penny only their pro rata share of overhead and incidental costs. They argue instead that the three surcharges differ from ordinary overhead costs in two important ways: first, plan participants derive no benefit from these surcharges; second, these surcharges are not equitably distributed to the general population, or to the State, or to even hospital users, but are placed squarely on the shoulders of commercial insurers and ERISA plans. As a result, they contend

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> whose tangential effects on employee benefits plans are negligible and wholly incidental to the law's primary purpose.

891 F.2d at 31.

The rejection of *Rebaldo* is understandable. It is not so much attributable to inconsistent decision making as to the court's recognition that ERISA preemption is as broad as the statute would suggest. The Court of Appeals for the Second Circuit decided *Rebaldo* in 1984, without the benefit of, among other cases. *Holliday*, *Pilot Life*, *Metropolitan Life*, *Mackey*, and *Ingersoll-Rand*

that they are forced to subsidize nonparticipant patients with ERISA funds.

The majority largely ignores these distinctions, choosing instead to sweep all state-mandated costs under the general penumbra of "overhead" costs. When states regulate, for example, utility, labor, education or medical sanitation, they increase the cost of doing business. To remain solvent and be able to provide services, businesses must be able to incorporate into prices these increases. In a market-based system, each consumer will pay for costs attributable to running the business, so overhead is part of the indirect costs associated with the purchase of goods and services. Since it is administratively impossible to isolate the precise actual costs attributable to any particular patient, many of the direct and indirect costs incorporated into the DRG such as overhead for management and maintenance are proper. The plans do not contend otherwise.

The surcharges are a different story, however. They are not indirect costs associated with *any* hospital services to plan beneficiaries. They are the direct cost of hospital services rendered to *other patients*, which have then been shifted to ERISA plans. One can argue, as the appellants do, that even businesses incorporate losses involved in stolen merchandises and bad debts into their prices. But the issue is not whether ERISA protects plans from the imposition of these kinds of costs because ERISA preempts only "state law" and not private action, or whether ERISA plans are entitled to nationally uniform hospital prices because that is impossible. The issue is whether state regulations have interfered with the operation of ERISA plans to the point where the plans have suffered large financial losses.

The argument that plans are affected the same way without regulations is based on questionable applications of economic assumptions. In a free market system, as well as most regulated systems, no business would knowingly sell to one who cannot in full or in part pay, whereas here New Jersey requires hospitals to provide services regardless of the ability to pay and then places the losses squarely on a small class of patients. Without the Act, the financial calculus and its effects on ERISA funds would change drastically. Since each hospital will have different rates depending in part upon their total losses, with urban hospitals, for example, incurring more losses from indigent care and bad debts, the plans would be free to select hospitals with the lowest prices. And even if hospitals distribute their losses by overcharging ERISA plans, the plans would

have an alternative: they would normally be free to negotiate with various hospitals for group rates just as some groups under the Act are able to negotiate lower rates (the difference of which ERISA funds have been forced to defray). Under the Act, however, the plans are in effect precluded from negotiating group rates because, as the State concedes, the Act takes away any incentive to negotiate when it prohibits hospitals from passing on to other patients any revenue shortfall caused by a digression from the DRG rates. But see Majority typescript at 29-30 ("Nor does [the Act] deprive ERISA plans of any alternative they would otherwise have in these areas.").

Moreover, in both market-based and regulated systems, businesses generally pass losses to *all* customers. Here, the object of the Act is to pass hospital losses inequitably to a small segment of hospital consumers. The surcharges are neither paid by the State nor the public at large; they are not even paid by all hospital users. The State created these surcharges with the specific intention that, in essence, only a small group of the hospital users — a large majority of whom comprise ERISA beneficiaries — would pay for them. While the plans do not derive *any* benefit, real or abstract, from the surcharges, the Act takes a substantial chunk of money belonging to ERISA beneficiaries, and all because New Jersey does not want to expend its general funds to pay for the health care costs of others who are less fortunate. As one affidavit summarized: "In effect, New Jersey requires the hospitals to give the service but will pay for it using other people's money, i.e., other users of the hospitals rather than a broader base revenue source such as general taxation."

Thus, the surcharges here are anything but "ordinary" overhead costs that indirectly increase the cost of doing business, and the argument that the Act simply sets prices does not sufficiently credit the direct financial impact on ERISA plans. The majority is correct insofar as states may regulate, for example, the disposal of medical waste and allow hospitals to pass these costs off to patients; but if states require hospitals to pass off these costs only or largely to "commercial insurers and self-funded union plans," such regulations must be preempted.

V.

I fear that the majority gives States free reign to spend and experiment with ERISA funds, held in trust for the many workers who

have labored long for their security, in the noble pursuit of health care reforms so long as States exercise a minimum degree of imagination by couching their statutes in "generally applicable" terms. When I consider the financial impact and other causal effect on ERISA funds in a common sense manner, the connection between ERISA plans and the Act is not too tenuous, remote or peripheral at all. The Act refers specifically to ERISA plans, divests enormous sums of money from ERISA plans, and is predicated on the existence of ERISA plans. In my opinion the Act "relates to" ERISA plans when that term is construed in its ordinary and broad meaning, and I dissent.

A True Copy:

Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 92-5317/5319/5320/
5341/5343/5345/5352/5354/5355

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; JACK STOLL; ESTHER BORJA; JAVIER RESTREPO; UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION LOCAL 464A, AFL-CIO GROUP REIMBURSEMENT WELFARE PLAN; FRANK LACATENA; DOLORES LACATENA; NEW JERSEY CARPENTERS WELFARE FUND; LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; TRUSTEES OF THE LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; PROSPER ALEXANDER; MARIE ALEXANDER; DISTRICT COUNCIL OF IRONWORKERS OF NORTHERN NEW JERSEY WELFARE FUND; ARCHIE G. FERGUSON; RONALD W. JENSEN; JOHN J. IRVINE; WALTER PHILLIPS; MICHAEL J. MCDERMOTT; SAMUEL PACICH; ALBERT J. IRWIN; NICHOLAS J. ANDRETTA, SR.; GARY UGARO; WALTER F. STEINMETZ; JOHN D. MULVANY; MICHAEL W. FEATHERSON; FRANCIS E. ARNY; JOHN J. CLARK, SR.; RONALD W. WILLIAMS; DANIEL J. PEREZ; KEITH E. ZDEP; EDWARD WEIDLER; LOUIS ROCCO; RAYMOND J. RODGERS; FRANCIS J. AKESSON; DONALD J. BANTA, SR.; CHARLES W. BIRD; DAVID F. BROWN; CLIFFORD CROOKS; ROBERT T. CUSICK; JAMES P. FITZGERALD; JOSEPH A. FUSARO; CHARLES GAMBA; RICHARD GOUGEON; JOHN KEATING; GERARD MCCLOUD; ROBERT MCGEE; ALEXANDER MCLELLAN; JOHN MURPHY; LAURENCE O'BRIEN; PETER O'CONNER; RAUL RODRIGUEZ; ROBERT SCHWEITZER; ROBERT SICKLES; ANDREW L. SMITH; RICHARD SPARKS; GEORGE SUDAK; EDWARD TEDESCO; JAMES TOAL; ENOCH P. MCMAHON; LOCAL UNION 400; IBEW WELFARE FUND;

BRIAN HRUSKA; WILLIAM MARSH; CHARLES WORK; HAROLD RUTLEDGE; RALPH ALLEN; THOMAS VADAS; VINCENT WORTH; TIMOTHY HILL; RONALD RAMSEY; JOHN IRELAND; JAMES MARTIN; MICHAEL ALMASI; BEVERLY A. RUBY; PETER NAMOTKA; DANIEL KENNEDY; GEORGE COLE; WALTER DAVIES; ROBERT HERMANN; FRANK HERMANN; CHARLES KELLER; DENNIS JOHNSON; CONNIE J. KOEHLER; FRANK O'DAY; VINCENT LA STELLA; DONALD MCNEIL; JEAN-LOUIS POULIOT; NICHOLAS AEMISEGO; ROBERT STAHNKE; PHILIP CERZA; GARY GIORGIO; EDWARD OSOWSKI; GLENN HALVORSEN; WILLIAM STADELMAN; DANIEL JULIO, JR.; FRANCIS ALEXANDER; LEONARD DAHL; MICHAEL DEVINE; JOSEPH GEORGE; RALPH JENSEN; DONALD LA BRUTTO; NORMAN GRAMLICH; JUAN ROMERO; JOSEPH PIWOSKI; HARRY PEASE, JR.; EUGENE O'ROURKE; PAUL NIEDZINSKI; BERNARD WALL; STEPHEN KOJAC; CHARLES KRUPKA; WILLIAM MCCORMACK; MINOR KENNARD; STEPHEN J. SANGLE; DONALD SCHIRALDO; JOHN GACINA, III; BRIAN MCCARTHY; CHARLES MCNALLY; ROBERT CZAJOWSKI; BRIAN WOODALL; JEFFREY STAHNKE; JOHN RYAN; RALPH ROSAMILIA, SR.; DANIEL MUGAN; EDWARD MIRONSKI; MICHAEL MIDDINGS; ANDREW MAHASKY; WALTER JELINSKY; ALBERT GAECHTER; LOUIS DI MASCIO; ELLIOTT ROSEMAN; TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; RICHARD HORNECKER; TEAMSTERS LOCAL 11 BENEFIT PLAN; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; KATLUSKA BAIDAL; WILLIAM BARTEL; GUNTER BLOHM; ANGELO BUINNO; BETTY J. CAIRNS; FRANK CLOSE; JOSE CRUZ; SANTOS GARCIA; KAREN GENSURE; DOROTHY LARSON; RICHARD LITCHFIELD; SANDRA MARINO; JOHN MATUSZKIEWICZ; GEORGE MCCLAUGHLIN; OLGA MONTES; FERNANDO PEREZ; SANTO RAMOS; MARTHA SARA; ROXEEN SCALA; EDMUND SCOTT; CHARLIE TAYLOR; MELISSA TURI, SANGPO TSULDIN; COSMO VISENTINI; NYSA-ILA WELFARE FUND; JOHN BOWERS; ALBERT CERNADAS; FRANK LONARDO; THOMAS POPOLA; JAMES CAPO; JOSEPH N. BARBERA; BART DIMATTINA; RICHARD H.

O'NEILL; LABORERS INTERNATIONAL UNION OF NORTH AMERICA LOCAL 415 HEALTH AND WELFARE FUND; SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND; JEFFREY STAJEK; JAMES LUCIANO; JOHN A. FREUDENREICH, SR.; THOMAS SMIECH; JOSEPH MCCALLION; DANIEL SMITH, JR.; JAMES MCKAY; MARK COX; TRUSTEES OF THE TEAMSTERS LOCAL 641 WELFARE FUND; CARLOS ROCHA; GEORGE KOESTER; CARMELA FERENS; KHOONRAJIE RAGHUBANS; PHILLIP SAVITTIERI; EAR PATTERSON; ROBERT REEDER; LOCAL 1245, LOCAL 1245 HEALTH FUND; ANTHONY RIZZO; JOSEPH ABBATE; JOSEPH MASSOUD; RALPH MASTRANGELO; TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475; WILLIE A. BARNES; HERMAN GEIGER; VINSTON LEE KING; KEVIN E. KLINE; ROBERT L. ROSA; WILLIAM BRENNAN; JAMES MURPHY, JR.; PATRICIA MCELLIGOTT; KEVIN MCCORMICK; PATRICK RYAN, JR.; ANTHONY E. SMITH; ROBERT LAVERATT; JOHN S. WITTEK; JOHN MCQUILKEN; JOHN MONTESANO; ROY E. FRANK; JOHN O'NEILL, JR.; FRANK ROBINSON; DALE SCHAEFER; JOHN J. SERRA; DONALD SHERIDAN; WENCESLAO SOTO; MICHAEL J. RUSSO; JOSEPH P. MURPHY, JR.; CALVIN R. SUTTON, III; RONALD J. ZAKARZEWSKI; FRANK WHITNEY, SR.; JACK NACHTIGALL; LAWRENCE PARKIN; EDISON RODRIQUEZ; WILLIAM MORAN; VINCENT DOFFONT; GEORGE STOUT; BRIAN LUBECK; AMERICO GUGLIELMO; DAVID VADAS; CHRISTOPHER ANDREWSKI; DAVID JENKINS; ARTHUR ACKERMAN; KENNETH FINTON; RAMON LORENZO; WESLEY SANDERSON; CHARLES NEWMAN, III; LEONARD IAROSSI; GEORGE ROSSI; WILLIAM SKIECZIUS; JOHN HANCOCK; EDWARD THORNE; JOSEPH TAGLIADIA; MICHAEL MACHANSKA; STEVE PARLACASK

v.

MORRISTOWN MEMORIAL HOSPITAL; FRANCES J. DUNSTON; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; NEW JERSEY COMMISSIONER OF HEALTH; FRANCES DUNSTON; MEMORIAL HOSPITAL OF BURLINGTON COUNTY; THE MEDICAL CENTER OF OCEAN COUNTY;

KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; OUR LADY OF LOURDES HOSPITAL; PRINCETON MEDICAL CENTER; HOSPITAL OF SALEM COUNTY; NEWCOMB MEDICAL CENTER; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; SHORE MEMORIAL HOSPITAL; BURDETTE TOMLIN MEMORIAL HOSPITAL; CHRIST HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; WAYNE GENERAL HOSPITAL; SOUTH JERSEY HOSPITAL SYSTEM; COOPER HOSPITAL; WEST JERSEY HEALTH SYSTEMS; ATLANTIC CITY MEDICAL CENTER; UNION MEMORIAL HOSPITAL; ELIZABETH GENERAL HOSPITAL; ENGLEWOOD HOSPITAL; ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; BARNERT MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL; RAHWAY HOSPITAL; VALLEY HOSPITAL; HOLY NAME HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; OVERLOOK HOSPITAL; ST. ELIZABETH HOSPITAL; DOVER GENERAL MEDICAL CENTER; HUNTERDON MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; KESSLER MEMORIAL HOSPITAL; FREEHOLD AREA HOSP.; KENNEDY MEMORIAL HOSPITAL; UNIVERSITY HOSPITAL; UNDERWOOD MEMORIAL HOSPITAL; JERSEY CITY MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; ST. BARNABAS MEDICAL CENTER; RARITAN BAY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; ST. CLARES/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; HACKETTSTOWN COMMUNITY HOSPITAL; ZURBRUGG MEMORIAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; MONMOUTH MEDICAL CTR; NEWTON MEMORIAL HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; DEBORAH HEART AND LUNG CENTER; HOSPITAL CENTER AT ORANGE; DOVER GENERAL HOSPITAL; WEST JERSEY HEALTH SYSTEM; RARITAN BAY MEDICAL CENTER; HACKENSACK MEDICAL CENTER; SOUTH AMBOY MEMORIAL HOSPITAL; THE MOUNTAINSIDE HOSPITAL; ST. FRANCIS HOSPITAL; BAYONNE HOSPITAL; MUHLENBERG HOSPITAL; CENTRASTATE (FAH) HOSPITAL, ST. JAMES HOSPITAL; KENNEDY MEMORIAL HOSPITAL AT SADDLE

BROOK; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DIVISION) OF MEDICAL ASSISTANCE AND HEALTH SERVICES; ELIZABETH GENERAL MEDICAL CENTER; DOVER GENERAL MEDICAL CENTER; IRVINGTON GENERAL HOSPITAL; UNION HOSPITAL; WARREN HOSPITAL, COLUMBUS HOSPITAL; EAST ORANGE GENERAL HOSPITAL, FRANCIS DUBEAU; LILLIAN DUBEAU; BAYSHORE COMMUNITY HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION; BERGEN PINES COUNTY HOSPITAL; COMMUNITY MEMORIAL HOSPITAL; GREENVILLE HOSPITAL; MONTCLAIR COMMUNITY (HOSPITAL) PALISADES GENERAL HOSPITAL; PASSAIC BETH ISRAEL HOSPITAL; RARITAN BAY MEDICAL CENTER/PERTH AMBOY DIVISION; RIVERVIEW MEDICAL CENTER; SOUTHERN OCEAN COUNTY HOSPITAL; ST. MARY'S HOSPITAL; THE GENERAL HOSPITAL CENTER AT PASSAIC; WALLKILL VALLEY HOSPITAL AND HEALTH CENTERS; ST. MARY'S HOSPITAL (PASSAIC); UNITED HOSPITAL; PASCACK VALLEY HOSPITAL; WEST HUDSON HOSPITAL; JOHNSON UNIVERSITY HOSPITAL; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; NEW JERSEY HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION,

Intervenor-Defendants

(Newark New Jersey District Consolidated Lead Civil No. 90-02639)

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; ESTHER BORJA

v.

ST. MARY'S HOSPITAL HOSPITAL; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; FRANCES J. DUNSTON;

(Newark New Jersey District Civil No. 90-03640)

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND; JAVIER RESTREPO

v.

ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-00073)

UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION, LOCAL 464A, AFL-CIO GROUP REIMBURSEMENT WELFARE PLAN; FRANK LACATENA; DOLORES LACATENA

v.

WAYNE GENERAL HOSPITAL; FRANCES J. DUNSTON; NEW JERSEY COMMISSIONER OF HEALTH; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-00336)

DISTRICT COUNCIL OF IRONWORKERS OF NORTHERN NEW JERSEY WELFARE FUND; ARCHIE G. FERGUSON; RONALD W. JENSEN; JOHN J. IRVINE, WALTER PHILLIPS; MICHAEL J. MCDERMOTT; SAMUEL PACICH; ALBERT J. IRWIN, NICHOLAS J. ANDRETTA, SR.; GARY UGARO; WALTER F. STEINMETZ; JOHN D. MULVANEY; MICHAEL W. FEATHERSON; FRANCIS E. ARNY; JOHN J. CLARK, SR.; RONALD W. WILLIAMS; DANIEL J. PEREZ; KEITH E. ZDEP; EDWARD WEIDLER; LOUIS ROCCO; RAYMOND J. RODGERS; FRANCIS J. AKESSON; DONALD J. BANTA, SR; CHARLES W. BIRD; DAVID BROWN; CLIFFORD CROOKS; ROBERT T. CUSICK; JAMES P. FITZGERALD; JOSEPH A. FUSARO; CHARLES GAMBA; RICHARD GOUGEON; JOHN KEATING; GERARD MCCLOUD; ROBERT MCGEE; ALEXANDER MCLELLAN; JOHN MURPHY; LAURENCE O'BRIEN; PETER O'CONNER; RAUL RODRIGUEZ; ROBERT SCHWEITZER; ROBERT SICKLES; ANDREW L. SMITH;

RICHARD SPARKS; GEORGE SUDAK; EDWARD TEDESCO; JAMES TOAL; ENOCH P. MCMAHAN

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; DEBORAH HEART AND LUNG CENTER; HUNTERDON MEDICAL CENTER; ST. FRANCIS HOSPITAL; HOSPITAL CENTER AT ORANGE; ST. PETERS MEDICAL CENTER; ST. CLARES/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; DOVER GENERAL HOSPITAL; ST. BARNABAS MEDICAL CENTER; VALLEY HOSPITAL; OVERLOOK HOSPITAL; RAHWAY HOSPITAL; NEWTON MEMORIAL HOSPITAL; WEST JERSEY HEALTH SYSTEM; RARITAN BAY MEDICAL CENTER; HACKENSACK MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; HOLY NAME HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; BAYONNE HOSPITAL; CHILTON MEMORIAL HOSPITAL; ST. JOSEPH'S HOSPITAL; MUHLENBERG HOSPITAL; COMMUNITY MED CENTER; CHRIST HOSPITAL; SOUTH AMBOY MEMORIAL HOSPITAL; CENTRASTATE (FAH) HOSPITAL; WAYNE GENERAL HOSPITAL; PRINCETON MEDICAL CENTER; ST. JAMES HOSPITAL,a/k/a CATHEDRAL HEALTH SERVICES, INC.; MOUNTAINSIDE HOSPITAL; PASSAIC GENERAL HOSPITAL; NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-02190)

NEW JERSEY CARPENTERS WELFARE FUND

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; SOUTH JERSEY HOSPITAL SYSTEM; COOPER HOSPITAL; WEST JERSEY HEALTH SYSTEMS; ATLANTIC CITY MEDICAL CENTER; MEMORIAL HOSPITAL OF BURLINGTON COUNTY; THE MEDICAL CENTER OF OCEAN COUNTY; KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; OUR LADY OF

LOURDES; PRINCETON MEDICAL CENTER; HOSPITAL OF SALEM COUNTY; NEWCOMB MEDICAL CENTER; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; SHORE MEMORIAL HOSPITAL; BURDETTE TOMLIN MEMORIAL; CHRIST HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; NEWARK BETH ISRAEL MEDICAL CENTER; WAYNE GENERAL HOSPITAL; UNION MEMORIAL HOSPITAL; ELIZABETH GENERAL HOSPITAL; ENGLEWOOD HOSPITAL, ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; BARNERT MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL; RAHWAY HOSPITAL; THE VALLEY HOSPITAL; HOLY NAME HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; OVERLOOK HOSPITAL; ST. ELIZABETH HOSPITAL; DOVER GENERAL MEDICAL CENTER; HUNTERDON MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; KESSLER MEMORIAL HOSPITAL; FREEHOLD AREA HOSPITAL; KENNEDY MEMORIAL HOSPITAL; UNIVERSITY HOSPITAL; UNDERWOOD MEMORIAL HOSPITAL; JERSEY CITY MEDICAL CENTER; ST. JOSEPH'S HOSPITAL; ST. BARNABAS MEDICAL CENTER; RARITAN BAY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER; ST. CLARE'S/RIVERSIDE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; HACKETTSTOWN COMMUNITY HOSPITAL; ZURBRUGG MEMORIAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; MONMOUTH MEDICAL CENTER; NEWTON MEMORIAL HOSPITAL; NEW JERSEY HOSPITAL, NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-03280)

LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; TRUSTEES OF THE LOCAL #807 LABOR-MANAGEMENT HEALTH FUND; PROSPER ALEXANDER; MARIE ALEXANDER

v.

UNIVERSITY HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; FRANCES J. DUNSTON, in

her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-03286)

LOCAL UNION 400, IBEW WELFARE FUND; BRIAN HRUSKA; WILLIAM MARSH; CHARLES WORK; HAROLD RUTLEDGE; RALPH ALLEN; THOMAS VADAS; VINCENT WORTH; TIMOTHY HILL, RONALD RAMSEY; JOHN IRELAND; JAMES MARTIN

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; THE MEDICAL CENTER OF OCEAN COUNTY; RIVERVIEW MEDICAL CENTER; COMMUNITY MEDICAL CENTER; JERSEY SHORE MEDICAL CENTER; KIMBALL MEDICAL CENTER; MONMOUTH MEDICAL CENTER NEW JERSEY HOSPITAL ASSOCIATION

Intervenor/Defendant

(Newark New Jersey District Civil No. 91-03897)

OVERLOOK HOSPITAL

v.

FRANCES DUBEAU; LILLIAN DUBEAU

(Newark New Jersey District Civil No. 91-03910)

LABORERS INTERNATIONAL UNION OF NORTH AMERICA LOCAL 415 HEALTH AND WELFARE FUND

v.

FRANCES J. DUNSTON. in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 91-04078)

NYSA-ILA WELFARE FUND, by its Trustees; JOHN BOWERS, Trustee; ALBERT CERNADAS, Trustee; FRANK LONARDO, Trustee; THOMAS POPOLA, Trustee; JAMES CAPO, Trustee;

JOSEPH N. BARBERA, Trustee; BART DIMATTINA, Trustee; RICHARD H. O'NEILL, Trustee

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; COLUMBUS HOSPITAL; EAST ORANGE GENERAL HOSPITAL ST. JAMES HOSPITAL; UNIVERSITY HOSPITAL, Individually and as Class Representatives of Hospitals in the State of New Jersey; NEW JERSEY HOSPITAL ASSOCIATION,
as Class representative of Hospital in the State of New Jersey

(Newark New Jersey District Civil No. 91-04259)

SHEET METAL WORKERS LOCAL UNION NO. 25 WELFARE FUND; JEFFREY STAJEK; JAMES LUCIANO; JOHN A. FREUDENREICH, SR.; THOMAS SMIECH; JOSEPH MCCALLION; DANIEL SMITH, JR.; JAMES MCKAY; MARK COX

v.

FRANCES J. DUNSTON, in her capacity of New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DIVISION) OF MEDICAL ASSISTANCE AND HEALTH SERVICES; NEW JERSEY HOSPITAL ASSOCIATION; ST. BARNABAS MEDICAL CENTER; HOLY NAME HOSPITAL; HACKENSACK MEDICAL CENTER; WEST HUDSON HOSPITAL; OVERLOOK HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; HUNTERDON MEDICAL CENTER; MORRISTOWN MEMORIAL HOSPITAL; IRVINGTON GENERAL HOSPITAL; CLARA MAASS MEDICAL CENTER

(Newark New Jersey District Civil No. 91-04700)

TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; RICHARD HORNECKER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT

OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND, NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

(Newark New Jersey District Civil No. 91-05362)

TEAMSTERS LOCAL 11 BENEFIT FUND; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; KATLUSKA BAIDAL; WILLIAM BARTELL; GUNTER BLOHM; ANGELO BUINNO; BETTY J. CAIRNS; FRANK CLOSE; JOSE CRUZ; SANTOS GARCIA; KAREN GENSURE; DOROTHY LARSON; RICHARD LITCHFIELD; SANDRA MARINO; JOHN MATUSZKIEWICZ; GEORGE MCCLAUGHLIN; OLGA MONTES; FERNANDO PEREZ; SANTO RAMOS; MARTHA SARA; ROXEEN SCALA; EDMUND SCOTT; CHARLIE TAYLOR; MELISSA TURI; SANGPO TSULDIN; COSMO VISENTINI

v.

BAYSHORE COMMUNITY HOSPITAL; CHILTON MEMORIAL HOSPITAL; CLARA MAASS MEDICAL CENTER; DOVER GENERAL HOSPITAL; ELIZABETH GENERAL MEDICAL CENTER; ENGLEWOOD HOSPITAL; HOLY NAME HOSPITAL; IRVINGTON GENERAL HOSPITAL; JERSEY CITY MEDICAL CENTER; PASSAIC GENERAL HOSPITAL; ST. FRANCIS HOSPITAL; ST. PETER'S MEDICAL CENTER; SOMERSET MEDICAL CENTER; UNION HOSPITAL; UNITED HOSPITAL; UNIVERSITY HOSPITAL; VALLEY HOSPITAL; WARREN HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 92-00085)

TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475; WILLIE A. BARNES; HERMAN GEIGER; VINSTON LEE KING; KEVIN E. KLINE; ROBERT L. ROSA; WILLIAM BRENNAN; JAMES MURPHY, JR.; PATRICIA MCELLIGOTT; KEVIN MCCORMICK; PATRICK RYAN, JR.;

ANTHONY E. SMITH; ROBERT LAVERATT; JOHN S. WITTEK; JOHN MCQUILKEN; JOHN MONTESANO; ROY E. FRANK; JOHN O'NEILL, JR.; FRANK ROBINSON; DALE SCHAEFER; JOHN J. SERRA; DONALD SHERIDAN; WENCESLAO SOTO; MICHAEL J. RUSSO; JOSEPH P. MURPHY, JR.; CALVIN R. SUTTON, III; RONALD J. ZAKARZEWSKI; FRANK WHITNEY, SR.; JACK NACHTIGALL; LAWRENCE PARKIN; EDISON RODRIGUEZ; WILLIAM MORAN; VINCENT DOFFONT

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; WEST HUDSON HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY; OVERLOOK HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; UNION HOSPITAL; RIVERVIEW MEDICAL CENTER; NORTHERN OCEAN HOSPITAL SYSTEM; COMMUNITY MEDICAL CENTER; HOSPITAL CENTER AT ORANGE; HUNTERDON MEDICAL CENTER; WARREN HOSPITAL; CENTRASTATE MEDICAL CENTER; SOMERSET MEDICAL CENTER; ROBERT WOOD JOHNSON UNIVERSITY; THE MEDICAL CENTER OF OCEAN COUNTY; JERSEY SHORE MEDICAL CENTER; COLUMBUS HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; CLARA MAASS MEDICAL CENTER

(Newark New Jersey District Civil No. 92-00426)

TEAMSTERS LOCAL 641 WELFARE FUND; CARLOS ROCHA; GEORGE KOESTER; CARMELA FERENS; KHOONRAJIE RAGHUBANS; PHILLIP SAVITTIERI; EARL PATTERSON; ROBERT REEDER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; MEDICAL CENTER OF OCEAN COUNTY; ST. BARNABAS MEDICAL CENTER; CLARA MAASS

MEDICAL CENTER; ST. ELIZABETH HOSPITAL; PASSAIC GENERAL HOSPITAL

(Newark New Jersey District Civil No. 92-00526)

LOCAL 1245 HEALTH FUND; LOCAL 1245 BAKERY AND SPECIALTY HEALTH FUND; JAMES ARBOLINO; ANTHONY ROCCO; HAROLD POLSKY; NEVIO MANCIINI; WILLIE SCONIERS; IRENE HICKEY; KATHLEEN RODRIGUEZ; WILLIAM CLACKWORTHY; EDWARD NELSON; PATRICIA CONRAD; RONALD COZZO; HOLLY ANN CULBERT; JOACHIM SCHAFFRANIETZ; HUBERT CHASE; ROBERT BAUMAN; RUSSELL SCHWARTZ; JEAN JACQUES KERVAN; ARTHUR BEYER

v.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; DOVER GENERAL HOSPITAL; THE MEDICAL CENTER OF OCEAN COUNTY; SAINT BARNABAS MEDICAL CENTER; UNION HOSPITAL; JOHN F. KENNEDY MEDICAL CENTER; ENGLEWOOD HOSPITAL; MORRISTOWN MEMORIAL HOSPITAL; CENTRASTATE; SAINT PETER'S MEDICAL CENTER; SAINT MARY'S HOSPITAL; MEADOWLANDS HOSPITAL AND MEDICAL CENTER; JERSEY SHORE MEDICAL CENTER; KENNEDY MEMORIAL HOSPITAL; PASSAIC GENERAL HOSPITAL

(Newark New Jersey District Civil No. 92-00728)

ANTHONY RIZZO; JOSEPH ABBATE; JOSEPH MASSOUD; RALPH MASTRANGELO, as Trustees of the Local 945, I.B.T. Welfare Fund

v.

BARNERT MEMORIAL HOSPITAL CENTER; BAYONNE HOSPITAL; BAYSHORE COMMUNITY HOSPITAL; BERGEN PINES COUNTY HOSPITAL; CENTRASTATE MEDICAL CENTER; CHILTON MEMORIAL HOSPITAL; CHRIST HOSPITAL; CLARA MAASS MEDICAL CENTER; COLUMBUS HOSPITAL; COMMUNITY MEMORIAL HOSPITAL; DOVER GENERAL HOSPITAL & MEDICAL

CENTER; ELIZABETH GENERAL MEDICAL CENTER; GREENVILLE HOSPITAL; HACKETTSTOWN COMMUNITY HOSPITAL, HOLY NAME HOSPITAL; IRVINGTON GENERAL HOSPITAL; JERSEY SHORE MEDICAL CENTER; JOHN F. KENNEDY MEDICAL CENTER; KENNEDY MEMORIAL HOSPITALS AT SADDLE BROOK; KIMBALL MEDICAL CENTER; MERCER MEDICAL CENTER; MONTCLAIR COMMUNITY (HOSPITAL); MORRISTOWN MEMORIAL HOSPITAL; NEWTON MEMORIAL HOSPITAL; OVERLOOK HOSPITAL; PALISADES GENERAL HOSPITAL, PASCACK VALLEY HOSPITAL; PASSAIC BETH ISRAEL HOSPITAL; RAHWAY HOSPITAL; RARITAN BAY MEDICAL CENTER/PERTH AMBOY DIVISION; RIVERVIEW MEDICAL CENTER; ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; SOUTHERN OCEAN COUNTY HOSPITAL; ST. MARY'S HOSPITAL (PASSAIC); ST. JOSEPH'S HOSPITAL & MEDICAL CENTER; ST. FRANCIS MEDICAL CENTER; ST. ELIZABETH HOSPITAL; ST. PETER'S MEDICAL CENTER; THE GENERAL HOSPITAL CENTER AT PASSAIC; UNION HOSPITAL; UNIVERSITY HOSPITAL; UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY; VALLEY HOSPITAL; WALLKILL VALLEY HOSPITAL AND HEALTH CENTERS; WARREN HOSPITAL; WAYNE GENERAL HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION

(Newark New Jersey District Civil No. 92-00849)

NEWCOMB MEDICAL CENTER

v.

JENNIS CARPENTER; ALICE CARPENTER, his wife, jointly, severally and in the alternative

Defendants/Third Party Plaintiffs

v.

FRANCES J. DUNSTON; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF

MEDICAL ASSISTANCE AND HEALTH SERVICES
Third Party Defendants

(Newark New Jersey District Civil No. 92-01282)

NEWCOMB MEDICAL CENTER

v.

SHANA TRIPP; CHARLES TRIPP, jointly, severally and in the alternative

Defendants/Third Party
Plaintiffs

v.

NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health

Third Party Defendants

(Newark New Jerseys District Civil No. 92-01454)

NEWCOMB MEDICAL CENTER

v.

FRED KUEKEN
Defendant/Third Party
Plaintiff

v.

FRANCES J. DUNSTON; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; ADMINISTRATOR OF THE NEW JERSEY HEALTH CARE TRUST FUND; NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
Third Party Defendants

(Newark New Jersey District Civil No. 92-01455)

New Jersey Hospital Association; Bayshore Community Hospital; Monmouth Medical Center; Pascack Valley Hospital; Riverview Medical Center; Kennedy Memorial Hospitals at Saddle Brook, Inc.; William B. Kessler Memorial Hospital; St. Francis Hospital;

South Jersey Hospital System; Helene Fuld Medical Center; Newton Memorial Hospital; The Medical Center of Ocean County; Bayonne Hospital; Kennedy Memorial Hospitals-University Medical Center; South Amboy Memorial Hospital; Underwood Memorial Hospital; Muhlenberg Regional Medical Center; Englewood Hospital; Zurbrugg Memorial Hospital; St. Mary Hospital; Community Medical Center; Hunterdon Medical Center; St. Michael's Medical Center; The Mercer Medical Center; St. Peter's Medical Center; Jersey Shore Medical Center; Irvington General Hospital; John F. Kennedy Hospital; Our Lady of Lourdes Medical Center; Overlook Hospital; Raritan Bay Medical Center; St. Elizabeth Hospital; Wayne General Hospital; Barnert Hospital; Atlantic City Medical Center; Dover General Hospital & Medical Center; Holy Name Hospital; The Hospital at Orange; St. Clare's/Riverside Medical Center; Clara Maas Medical Center; Deborah Heart & Lung Center; Rahway Hospital; West Jersey Health System; Hackensack Medical Center; Newark Beth-Israel Medical Center; St. James Hospital; St. Joseph's Hospital & Medical Center; Christ Hospital; Chilton Memorial Hospital; East Orange General Hospital; Columbus Hospital; Cooper Hospital/University Medical Center; Memorial Hospital of Burlington County Memorial Health Alliance; Medical Center at Princeton; St. Joseph's Hospital; Shore Memorial Hospital; Robert Wood Johnson University Hospital; Burdette Tomlin Memorial Hospital; Somerset Medical Center; Mountainside Hospital; Union Hospital; United Hospitals Medical Center at Passaic; and Morristown Memorial Hospital,

Appellants

On Appeal From the United States District Court For the District of New Jersey

(D.C. Civil Action Nos. 90-02639, 90-03640, 91-00073, 91-00336, 91-02190, 91-03280, 91-03286, 91-03897, 91-03910, 91-04078, 91-04259, 91-04700, 91-05362, 92-00085, 92-00426, 92-00526, 92-00728, 92-00849, 92-01282, 92-01454, 92-01455)

Present: STAPLETON, SCIRICA, and NYGAARD,
Circuit Judges

J U D G M E N T

This cause came to be heard on the record from the United States District Court for the District of New Jersey and was argued by counsel September 18, 1992.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court entered May 28, 1992 and amended by order entered June 5, 1992, be, and the same is hereby reversed. The injunction is vacated and the cause is remanded to the District Court with instructions that judgment be entered for the defendants. All of the above in accordance with the opinion of this Court.

ATTEST:

Acting Chief Deputy Clerk

Dated: May 14, 1993

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 92-5317/5319/5320/5341/5343/5345/5352/5354/5355

UNITED WIRE, METAL AND MACHINE HEALTH AND WELFARE FUND, ET AL.
V.
MORRISTOWN MEMORIAL HOSPITAL, ET AL.

SUR PETITION FOR REHEARING

BEFORE: SLOVITER, *Chief Judge*, BECKER, STAPLETON, MANSMANN, GREENBERG, SCIRICA, COWEN, NYGAARD, ALITO, ROTH, and LEWIS,
Circuit Judges

The petition for rehearing filed by appellees The trustees of the teamsters Local 11 Benefit Plan, Katulska Baidal, et al., New Jersey Carpenters Welfare Fund, District Council of Iron Workers of Northern New Jersey Welfare Fund, Local Union 400, IBEW Welfare Fund, Teamsters Local 641 Welfare Fund, Local 1245 Health Fund, Local 1245 Bakery & Specialty Health Fund, Trustees of the Welfare Trust Fund Local Union 475, et al., Teamsters Local 11 Benefit Plan, United Wire, Metal and Machine Health and Welfare Fund, Operating Engineers Local 825 Welfare Fund, NYSA-ILA Welfare Fund and Its Trustees, Local 807 and Trustees of Local 807, United Food & Commercial Workers International Union Local 464A, AFL-CIO Group Reimbursement Welfare Plan, Frank Lacatena and Dolores Lacatena, Sheet Metal Workers Local Union No. 25 Welfare Fund, Jeffrey Stajek, et al., Laborers International Union of North America Local 415 Health & Welfare Fund and the Hotel Employees and Restaurant Employees Welfare Fund, et al., in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active

service not having voted for rehearing by the court in banc, the petition for rehearing is denied. Judge Nygaard would have granted the petition for rehearing.

By the Court,
/s/

Circuit Judge

Dated: JUNE 15, 1993

United States District Court

FOR THE DISTRICT OF NEW JERSEY

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, et al.,

Plaintiffs,

v.

MORRISTOWN MEMORIAL HOSPITAL, et al.,

Defendants.

Civil Action No. 90-2639 (Consolidated)

OPINION

APPEARANCES:

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WOLIN, District Judge

Currently before the Court are defendants' and plaintiffs' cross-motions for summary judgment. Initially, this Court finds that the Eleventh Amendment does not prevent this Court from deciding any claims brought against the state agencies and the officials employed by the State of New Jersey. Likewise, this Court finds that New Jersey's hospital rate setting mechanism does not constitute a tax, and therefore the Tax Injunctive Act does not foreclose this Court from deciding the issues before it.

This Court will grant defendants' motions for summary judgment as to plaintiffs' federal constitutional claims. This Court further holds, however, that ERISA pre-empts certain provisions included in New Jersey's scheme for regulating hospital rates and the regulations promulgated thereunder. Therefore, this Court finds that New Jersey's hospital rate setting scheme is unenforceable. Due to the potential impact of its decision, this Court will stay its Order for a period of ten days to afford the parties an opportunity to appeal the Court's ruling to the Third Circuit Court of Appeals.

I. INTRODUCTION

Several self-insured union employee welfare benefit plans (the "Benefit Plans") qualified under the Employee Retirement Security Act 29 U.S.C. § 1002 *et seq.*, as amended ("ERISA") and their participants (the "individual plaintiffs") (collectively the "plaintiffs"), have brought an action in which they seek a declaration that contained New Jersey's scheme for setting hospital rates is invalid.[1] Plaintiffs argue that this Court must strike down the method New Jersey utilizes for determining hospital rates on both federal and state constitutional grounds and because ERISA pre-empts the state statute.

The gravamen of the complaint focuses on charges included within the hospital billing procedure which are in excess of a patient's "actual hospital costs." These include: costs of care for the indigent, charges to pay a hospital's bad debts, subsidies for the medicare program, and fees to reimburse hospitals for discounts given by the hospitals to other types of benefit plans.

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[1] This action was consolidated pursuant to order on January 31, 1992.

This Court has jurisdiction over plaintiffs' claims brought under the United States Constitution, ERISA and the Taft-Hartley Act pursuant to 28 U.S.C. § 1132. This Court has jurisdiction over plaintiffs' causes of action that arise under New Jersey's Constitution under the principles of pendent jurisdiction and supplemental jurisdiction, 28 U.S.C. § 1367.

In the exercise of its discretion, however, this Court declines to consider the Carpenter's Union's claim that this Court should force the Hospital Defendants to reimburse the charges paid by the Carpenter's Union under protest. The Court declines to exercise its pendent jurisdiction and supplemental jurisdiction over this state law claim in the interest of comity. The Carpenter's Union argues that the fees should be reimbursed because they were paid under compulsion — the hospital rate setting regulation forces a hospital to institute collection actions against parties who refuse to pay DRG rates. The New Jersey State Court's have never faced this issue. Moreover, the Hospital Defendants commenced related actions, which are currently pending in New Jersey, in which they seek reimbursement from plaintiffs who failed to pay the contested charges. In view of the interrelatedness of these actions, this Court will defer to the New Jersey State Courts.[2] Venue is proper in this district under 28 U.S.C. § 1391.

II. BACKGROUND

In 1971 New Jersey enacted the Health Care Facilities Planning Act (the "Act"), a hospital rate setting scheme for Blue Cross and certain federally funded programs such as Medicaid. L. 1971 c. 136 § 18. Rates were based primarily on a hospital's actual costs for each patient who participated in the programs encompassed by the law. In 1978, New Jersey passed a statute that amended the 1971 legislation and, in part, mandated rate setting for all payors. L. 1978 c. 83 ("Chapter 83"). Chapter 83 contained a dual purpose:

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[2] In their brief in opposition to the hospital defendants motion for summary judgment, plaintiffs concede that they are not asking this Court to apply its decision retroactively, but merely seek restitution because they paid the DRG rate under protest and duress. Accordingly, the issue of when to apply a decision retroactively under federal law does not confront this court. Thus, this Court can refuse to exercise its pendent jurisdiction over plaintiffs restitution claims.

to "contain the rising costs of health care services, and to ensure the financial solvency of hospitals."

Chapter 83 designed an interconnected regulatory system to embrace its purposes. Chapter 83 gave the Commissioner of Health (the "Commissioner") responsibility for overall supervision and administration of the hospital rates. The Commissioner, in conjunction with the Health Care Administration Board (the "Board"), proposes the rate schedule and determines, in accordance with the statute, the types of charges that should be included in hospital rates. Additionally, the law created the New Jersey Hospital Rate Setting Commission (the "Commission"). The Commission approves hospital rates. N.J.S.A. 26:2H-4.1; 26:2H-18.1; 26:2H-18.9; N.J.A.C. 8:31B-3.72; N.J.A.C. 8:31B-3.39. The New Jersey Department of Health (the "DOH") oversees the Commission and administers the rates.

In order to help contain costs, Chapter 83 set hospital rates prospectively, instead of upon actual cost. Under Chapter 83, various procedures are divided into diagnostic related groups ("DRG"), and a rate is assigned to each DRG. Instead of charging actual costs incurred by a hospital for treating an individual patient, the hospital has to charge the DRG rate which is designated for that classification. Despite the calculation of bills without regard to actual costs, a hospital bill still reflects a charge that previously represented actual costs. This charge is categorized as "total costs." A "DRG" charge also appears on a patient's bill.

A particular hospital's DRG rate consists of a weighted average of the cost incurred by that specific hospital to treat a particular illness and the average cost incurred by hospitals throughout the state to treat the condition. Accordingly, this system penalizes a hospital that incurs costs greater than that allocated to a particular DRG category and rewards hospitals that provide more efficient services for a particular DRG.[3]

Additionally, as part of its DRG rate, a hospital must include a charge for uncompensated care. Uncompensated care consists of

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[3] The costs incurred by a hospital include both direct costs and indirect costs. Direct costs include salaries and fringe benefits provided to employees engaged in the direct delivery of patient care, N.J.A.C. 8:31B-3.21, N.J.A.C. 8.31B-3.16. Indirect costs consists of funds expended by a hospital in order to manage the hospital, to allow the hospital to engage in research and to provide for the maintenance needed to upkeep a hospital.

both care to the indigent and expenses that result from bad debts. N.J.S.A. 26-2H 18.d; N.J.A.C. 8:31B-3.41; 8:31B-7.1. This charge stems from a hospital's mandate to admit anyone regardless of his or her ability to pay.[4] Only hospital patients incur costs for uncompensated care. In order to receive funds for uncompensated care a hospital must determine whether a patient has any health insurance.

Furthermore, hospitals that treat patients who have Medicare can recoup only the amount allotted by the Medicare system for the particular treatment. Medicare invariably pays less than the DRG rate allocated for a particular condition. N.J.S.A. 26H-18.1c, however, permits the Commissioner with the approval of the Board, "to adjust the DRG rate to account for costs incurred by statutes and regulations that affect the delivery of health care." Pursuant to this statute, the Commissioner, with the Board's approval, enacted N.J.A.C. 8:31B:3.73. This regulation allows the hospitals to include in their DRG rate an amount necessary to recover the difference between the Medicare rate of payment and the DRG rate. These costs are borne by non-medicare patients.

Moreover, Chapter 83 allows the Commission to decrease hospital costs for certain classes of payors. In particular, the Commission may grant a "payor differential" if it is supported by a "quantifiable economic benefit such as the degree of promptness and volume of payment to the hospital." N.J.S.A. 26:2H-18b. Pursuant to this provision, the Commission has granted a 2.2% discount to plans such as Blue Cross. None of the Benefit Plans currently receive such a discount. Only the Carpenter's Union Trust Fund (the "Carpenter's Union"), has requested such a discount. The Commission has not yet reached a decision as to the Carpenter's Union's application.

In addition to the 2.2% discount the Commission grants an 11% discount to plans with open enrollment. Because the Benefit Funds

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[4] The 1978 Amendments mandated an inclusion in the DRG rate for uncompensated care costs. The uncompensated care costs attributed to a particular hospital was borne only by that hospital's patients. In 1987 New Jersey again amended the hospital rate setting system. Under the Amendments, hospitals throughout the state shared equally in the cost of uncompensated care. Thus, the hospital bill of each patient is increased by the same amount in order to compensate hospitals for uncompensated care costs. Currently, a hospital increases a patient's bill 19% for uncompensated care. The New Jersey Health Care Trust Fund then distributes the money collected for uncompensated care to each hospital according to that particular hospital's needs.

must limit their enrollment to union members and their families, the Benefit Funds cannot receive this discount. The bills of patients who did not belong to plans that received these discounts were increased in order to supply hospitals with the reduced income they lost because of the discounts. N.J.A.C. 8:31B-3.39.

Regulations, promulgated in accordance with the rate setting scheme, contain an appeal process for individuals whose DRG costs exceed their total costs by $250.00. Individuals who have third party insurance that does not reimburse the hospital according to DRG rates or that contains a deductible are not eligible to appeal. Accordingly, none of the individual plaintiffs can avail themselves of the appeal process.

The Benefit Plans do not provide the same type of payments for hospital costs incurred by their members. For example, the District Council of Ironworkers of Northern New Jersey Welfare Fund (the "IWF") Benefit Plan covers 95% of the actual hospital costs incurred by its members.[5] The NYSA-ILA Welfare Plan, however, compensates the hospital for about 75% of the total fees charged to its participants. Still, other Benefit Plans pay 100% of the DRG charges.

Plaintiffs instituted their Second Amended Complaint against certain New Jersey entities and administrators employed by New Jersey who are associated with the rate setting provisions (the "State Defendants").[6] Plaintiffs also sued various hospitals (the "Hospital Defendants") (with the State Defendants collectively the "defendants"). The Hospital Defendants must charge DRG rates in order to maintain the licenses that permit the hospitals to provide health care.

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[5] Prior to April 16, 1991, the IWF paid 95% of the DRG rate imposed by the hospitals. Concurrent with its decision to reimburse only 95% of actual hospital cost, the IWF instructed its members to submit only the 5% difference in total costs to the hospitals. Mandated by the Act the hospitals have begun collection procedures in state court to recoup the unpaid DRG charges. Following its decision to reimburse only 95% of total costs the IWF placed the difference between 95% of the DRG rate and 95% of total costs into an escrow account.

[6] Specifically, plaintiffs named the DOH, the Commission, the Administrator of the New Jersey Health Care Trust Fund, the Department of Human Services Division of Medical Assistance and Health Services and the Commissioner of Health as defendants.

In their complaint, plaintiffs allege that this Court must strike down New Jersey's hospital rate setting scheme for the following reasons: (1) the scheme is pre-empted by § 501(a) of ERISA, 29 U.S.C. § 1132(a), and by § 186(c) of the Taft Hartley Act, 29 U.S.C. § 186(c)[7]; (2) it deprives plaintiffs of the due process and equal protection rights guaranteed to them under the Constitutions of the United States and the State of New Jersey; (3) it constitutes a taking of property without just compensation under the United States Constitution; (4) it imposes a special tax law in violation of the New Jersey Constitution; and (5) it improperly delegates taxing power to the Commissioner because it gives the Commissioner "unchecked power" to establish hospital rates.

In addition to contesting each of the allegations asserted by plaintiffs, the defendants contend that this Court has no authority to hear this case. First, the State Defendants assert that the Eleventh Amendment protects them from the instant lawsuit. Second, the defendants allege that if the hospital rates constitute a tax, the Tax Injunctive Act prohibits this Court from hearing the instant motion.

III. DISCUSSION

A. State Immunity Under the Eleventh Amendment

The State Defendants allege that they have not consented to suit and therefore, the Eleventh Amendment forecloses any action against them. The Eleventh Amendment does not prohibit suits for prospective injunctive relief and declaratory relief against state agencies and state officials where plaintiffs contend that actions taken by these agencies and officials, in their official capacity, have violated the federal constitution or federal statutes. *Geis v. Board of Education of Parsippany-Troy Hills*, 744 F.2d 575, 580 (1985). This exception to immunity applies even if issuing the declaratory or injunctive relief would reduce state funds. *Edelman v. Jordan*, 415 U.S. 651-52, 94 S. Ct. 1347 1358-59 (1974). Similarly, suits that seek injunctive relief and assert that the state exceeded powers granted to it by its own constitution are not prohibited by the Eleventh Amendment. *Capitol Industries-Emi, Inc. v. Bennett*, 681 F.2d

[7] Plaintiffs have offered no support for their preemption claim brought under the Taft-Hartley Act. Moreover, plaintiffs concede that preemption under § 186(c) applies more narrowly than under § 501(a) of ERISA. Therefore, this Court rejects plaintiffs preemption claim under the Taft-Hartley Act.

1107, 1120 (9th Cir.), *cert. denied*, 459 U.S. 1087, 103 S. Ct. 570 (1982).

Because plaintiffs seek solely prospective injunctive and declaratory relief, the Eleventh Amendment does not bar their action commenced against any State Defendant. Moreover, even if this Court's ruling decreases funds available to the state with which they can help defray the costs of medical expenses of its citizens, this still does not foreclose this action against the State Defendants. Likewise, the Eleventh Amendment does not preclude plaintiffs' claim that the Legislature unconstitutionally delegated the taxing power to the Commission.

B. Application of the Tax Injunction Act (the "TIA")

Before this Court can consider the merits of the motions before it, the Court must decide whether the TIA bars any of plaintiffs claims. The TIA provides:

> The district court shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State.

28 U.S.C. § 1341. Accordingly, in order to determine whether an action falls under the TIA the Court conducts a two-step analysis. First, the Court must determine if the charge at issue constitutes a tax. If the expense is a tax, then the Court must decide whether the State provides a "plain speedy and efficient remedy." 28 U.S.C § 1341[8]

At the outset, this Court notes that the TIA clearly applies to the types of claims and relief that plaintiffs seek. First, it is well settled that actions for declaratory relief as well as for injunctive relief are barred by the TIA. *See Franchise Tax Board v. Alcoa Aluminum, Ltd.*, 493 U.S. 331, 110 S. Ct. 661 (1990). Additionally, the TIA encompasses federal constitutional challenges to the imposition of a state tax. *See Hardwick v. Cuomo*, 891 F.2d 1097, 1100 (3d Cir. 1989) (plaintiffs' equal protection challenge to imposition of non-resident tax barred by TIA).

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[8] The Third Circuit has held that the TIA is a jurisdictional statute. *Sipe v. Amerada Hess Corp.*, 689 F.2d 396 (3d Cir. 1982). Hence, the Court cannot hear any matters that fall within the scope of the TIA.

Congress enacted the TIA in order to "prevent federal court interference with the assessment and collection of state taxes" by parties who brought suits in federal court to enjoin a state or local government's collection of taxes. *Hardwick*, 891 F.2d at 1105. Congress recognized that states had a "pressing need" to collect revenues. As a result, state and local governments "would compromise [a party's claim] by taking less than the tax due." *Tramel v. Schrader*, 505 F.2d 1310, 1315 (5th Cir. 1975).

The difficult question faced by this Court is whether any of the costs included in the DRG rate constitute a tax. Initially, this Court finds that it must conduct its analysis under federal and not state law. *Robinson Protective Alarm Company v. Philadelphia*, 581 F.2d 371, 374 (3d Cir. 1978) ("'[T]ax under state law' in 28 U.S.C. § 1341 should be determined as a matter of federal law by reference to congressional policies underlying the Tax Injunction Act, rather than by adoption of state tax labels developed in entirely different legal contexts.").[9]

No bright-line exists between assessments which are "taxes under state law" and those which are not. Recently, the court in *Butler v. Maine Supreme Judicial Court*, 767 F. Supp. 17, 18 (D. Me. 1991), concisely stated the accepted definition of "taxes." In general, "assessments imposed primarily for revenue raising purposes are 'taxes,' while those levies assessed for regulatory or punitive purposes, even though they may also raise revenues, are generally not 'taxes.' " *Id.* (citations omitted).

The Third Circuit has followed this definition. For example, in *Robinson*, the Third Circuit held that an assessment of 5% of gross earnings levied upon alarm station companies who used underground wires constituted taxes. The Court examined the character of the assessments. It found that the taxes were "collected annually in a manner similar to other gross receipts levied." Moreover, it noted that the monies collected were "added to the public fisc rather than applied exclusively to contractual services owed central alarm station companies."[10] Thus, the court concluded that Philadelphia

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[9] Accordingly, plaintiffs' argument that the "add-ons" constitute a tax because the Commission on Hospital Rates termed them as such is of no moment to this Court.

[10] Plaintiffs argument that the DRG rates constitute taxes because matching funds collected from the federal government under the Medicare Program are placed in the public fisc is simply a red herring. This Court must only determine whether

taxed the plaintiffs under the TIA. *See also Butler*, 767 F. Supp. at 17 (D. Me. 1991) (state exacted tax from plaintiffs when it imposed $300 jury fee on plaintiffs in state court action. Fees collected were "funnelled into Maine's general fund [and not] applied directly to the costs of jury trials.").

The dictum announced by the Third Circuit supports the conclusion that if Philadelphia applied the revenue collected to the regulated industry, the court would have held that Philadelphia did not tax the alarm station companies. *Cf. Rural Telephone Coalition v. F.C.C.*, 838 F.2d 1307 (D.C. Cir. 1988) (FCC order to allocate 25% of traffic sensitive costs from local telephone companies to long distance telephone did not impose a tax. Primary purpose of the ruling was not to raise revenue but only to regulate rates.); *Brock v. Washington Metropolitan Area Transit Authority*, 796 F.2d 481 (D.C. Cir. 1986), *cert. denied, Washington Metropolitan Transit Authority v. Brock*, 481 U.S. 1013, 107 S. Ct. 1887 (1987) (statute that mandated employers to contribute to special fund from which several types of workers compensation payments were made did not impose taxes on employers. Statute's primary purpose was to "regulate liability for industrial accidents" and not to finance the government's general programs. Fund was segregated from other fees collected.) *Head Money Cases*, 112 U.S. 580 (1884) (Duty on immigrants collected from shipowners and segregated into its own fund which was imposed in order to defray the expense of regulating immigration and for the care of immigrants did not exact a tax from shipowners but instead only implicated the Commerce Clause).

Guided by the dictum in *Robinson*, this Court holds that the contested costs included in the DRG rate do not constitute a tax. The state never uses the money collected from plaintiffs for the general welfare. Additionally, the fees collected are never intermingled in a general fund. Instead, the fees defray the costs that hospital's incur pursuant to state regulation of hospital costs. Hence, this Court finds the TIA does not apply. Accordingly, this Court has jurisdiction over plaintiffs' claims.

(Continued)
the costs included within the DRG rate constitute a tax. Money obtained by New Jersey from the federal government that are related to some of the DRG costs has no bearing on this analysis.

Courts in various circuits have found that special assessments collected by the government to fund specific programs constitute a tax under the TIA. For example, in *Tramel*, the Fifth Circuit held that a special street improvement assessment levied on plaintiffs who owned land which abutted the streets that the City wanted to improve constituted a tax. 505 F.2d at 1312. The court reasoned that to hold otherwise would defeat the purposes of the TIA. In particular, the court held a contrary finding would permit parties to "delay or to frustrate the revenue collection process by resorting to federal courts." *Id.* at 1316.

Similarly, the Sixth Circuit held that a state law which required "parolees to make monthly payments to a supervision fund and to a victim's compensation fund," imposed a tax on parolees. *Wright v. McClain*, 835 F.2d 143 (6th Cir. 1987). The Sixth Circuit acknowledged that the funds collected were used only by the Corrections Department. *Id.* at 145. The Sixth Circuit reasoned, however, that the fees constituted revenue because they were used "[by the government] to defray the cost to the general public of monitoring and supervising the behavior of convicted offenders and to compensate, in some measure, victims of criminal misconduct." *Id.* Thus, the court concluded that even though the funds were earmarked for a particular use by the state they were taxes.

The decisions discussed above do not disturb the Court's holding. Unlike the cases cited above, the charges included in the DRG rate do not fund special programs financed by New Jersey. Instead, they allow hospitals regulated by New Jersey to meet their financial obligations. Therefore, the TIA is inapplicable to the action before this Court.[11]

C. ERISA Pre-emption

Plaintiffs argue that ERISA pre-empts the method New Jersey utilizes for establishing hospital rates. Initially, plaintiffs contend that ERISA pre-empts Chapter 83's method of setting hospital

[11] Because this Court finds that costs included in the DRG rates are not taxes, this Court will not determine whether the TIA applies to actions brought under ERISA.

rates, determining who is eligible to appeal DRG costs, and deciding who can receive a discounted rate, because these provisions "relate" to an employee benefit plan. Plaintiffs further allege that the charges included in the DRG rates for uncompensated care, Medicare, and appeals granted to individuals constitute taxes that are impermissible under an express provision of ERISA because they relate to an employee benefit plan.[12]

ERISA contains an explicit pre-emption provision. Section 514(a) of ERISA pre-empts state laws that "relate to any employee benefit plan." 29 U.S.C. § 1144(a) ("§ 514(a)"). The Supreme Court has consistently interpreted the pre-emption clause broadly. *See FMC v. Holliday Corp.*, 111 S. Ct. 403, 407 (1990) ("The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that 'relates to' an employee benefit plan governed by ERISA."); *Franchise Tax Board*, 463 U.S. 1, 24, 103 S. Ct. 2841, 2854 n.26 ("ERISA's commodious pre-emption provision is virtually unique."). Accordingly the Supreme Court has refused to define "relate to" narrowly. Instead, the Supreme Court has announced:

> A law relates to an employee benefit plan in the normal sense of the phrase if it has a connection with or reference to such a plan.

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 1552 (1987).

Guided by the broad language contained in the preemption clause, the Supreme Court has held that ERISA pre-empts a state law even where a state law affects ERISA indirectly or the law was not "specifically designed to affect such plans." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525, 101 S. Ct. 1895, 1907 (1981). Similarly, the Supreme Court has held that the preemption clause does not apply only to "state laws dealing with the subject matter covered by ERISA: reporting, disclosure, fiduciary responsibility and the like." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97-98, 103 S. Ct. 2890, 2900. Moreover, ERISA pre-empts a state law even if the law "[is] consistent with ERISA's substantive requirements." *Metropolitan Life Insurance Co. v. Massachusetts*,

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[12] Because this Court finds that ERISA pre-empts New Jersey's method of setting hospital rates, regardless of whether the charges challenged by plaintiffs constitute a tax, this Court will not decide the tax issue.

471 U.S. 724, 105 S. Ct. 2380, 2388-89 (1985) (citing) 103 S. Ct. at 2900-2901, or the law was enacted to "effectuate ERISA's underlying purposes." *Mackey v. Lanier Collection Agency & Service Inc.*, 486 U.S. 825, 108 S. Ct. 2182, 2185 (1988).

In *Ingersoll-Rand Co. v. McClendon*, ____U.S. ____, 111 S. Ct. 478, 484 (1990), the Supreme Court recently affirmed the broad reach of ERISA. In *Ingersoll*, the defendant contended that § 514(c)(2) of ERISA limited the scope of § 514(a). Section 514(c)(2) provides:

> The term State includes a State, any political subdivisions thereof, or any agency or instrumentality of either which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter. 29 U.S.C. § 1144(c)(2).

(Emphasis added). Based on ERISA's definition of "State," the defendant in *Ingersoll* concluded that § 514(a) only applies to state laws that "affect plan terms, conditions, or administration [of an ERISA plan]."

The Supreme Court, however, rejected this argument. First, the Supreme Court explained that Congress expanded the definition of state in order to enlarge the grasp of ERISA. Hence, defendant's restrictive reading of § 514(a) would defeat Congress's purposes. Second, the Supreme Court concluded that if Congress intended to restrict § 514(a) in the manner proposed by defendant it would have included the limiting language in § 514(a) itself. *Id.* Therefore, the Supreme Court refused to narrow the reach of the plain meaning of the language contained in § 514(a).

The Supreme Court's broad reading of ERISA's preemption clause stems not only from the plain meaning of the provision itself, but also from the legislative history of ERISA. Specifically, Congress rejected a pre-emption clause that only "appli[ed] to state laws [which] relat[ed] to the specific subjects covered by ERISA." *Shaw*, 103 S. Ct. at 2900; *FMC*, 111 S. Ct. at 408. Similarly, Congress excluded a state's "generally applicable criminal laws" from pre-emption. *Id.* Such an exclusion would have been unnecessary if Congress intended § 514(a) to apply only to "state laws dealing specifically with ERISA plans." 103 S. Ct. at 2900; 111 S. Ct. at 408.

Finally, the legislative history reveals that Congress enacted ERISA in order to give federal authorities "sole power to regulate the field of employee benefit plans." *Pilot Life Ins. Co.*, 107 S. Ct. at 1552 (quoting) 120 Cong. Rec. 29197 (1974). Accordingly, Congress enacted a broad pre-emption clause in order to "eliminate the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Id.* (quoting) 120 Cong. Rec. at 29933.

Following the dictates of Congress, the Supreme Court has held that ERISA superseded state laws that forced a benefit plan to structure benefits in a specific manner. Similarly, the Supreme Court has invalidated state laws that could subject an ERISA plan to inconsistent state regulations. As noted above, whether a state law mentioned ERISA plans was not a critical factor in the Supreme Court's decision.

For example, in *Alessi*, 451 U.S. at 508-09, 101 S. Ct. at 1898, New Jersey forbade reducing retirement benefits or payments by the amount of money a person received under worker's compensation. The Supreme Court held that ERISA pre-empted New Jersey's law. In particular, the Supreme Court found that New Jersey's law impermissibly "eliminate[d] one method for calculating pension benefits." As a result, New Jersey's regulation would force a pension plan either to change its manner for computing benefits for all plans both within and outside New Jersey or to require the plan to calculate benefits for New Jersey employees in a manner different from the manner used for employees outside New Jersey. Moreover, the Supreme Court reached its conclusion irrespective of the New Jersey law's beneficial purposes. Additionally, the Supreme Court held that it made no difference that "New Jersey intrudes indirectly through workers compensation rather than directly through a statute called pension regulation." Importantly, although the Supreme Court recognized that New Jersey's law constituted an exercise of its police powers, the Court still held that ERISA pre-empted the law.

Likewise, in *FMC*, 111 S. Ct. at 406, the Supreme Court held that ERISA pre-empted Pennsylvania's anti-subrogation law. Pennsylvania's law prohibited a party from subrogating his or her tort recovery "in an action arising out of the maintenance or use of a motor vehicle" to any plan that paid the party benefits related to the accident. *Id.* Contrary to Pennsylvania's law, the benefit plan at

issue in *FMC* provided that a participant would reimburse the plan with any recovery obtained from a third party.

In reaching its conclusion, the Supreme Court found that Pennsylvania's law restricted the way in which the plan could provide benefits. Additionally, the Court reasoned that Pennsylvania's statute would subject the plan to inconsistent regulations. This would "frustrate plan administrators continuing obligation [under ERISA] to calculate uniform benefit levels nationwide." Therefore, the Supreme Court held that Pennsylvania's anti-subrogation law was unenforceable.[13] *See also Shaw*, 463 U.S. 85, 103 S. Ct. 2890 (1983) (ERISA pre-empted New York law that mandated benefits for pregnancy. Law forced ERISA plans to structure benefits in a particular manner and subjected plans to inconsistent regulations).

Following the Supreme Court's interpretation of § 514(a), the Eighth Circuit held in a recent decision that ERISA pre-empted Arkansas' general assignment statute. The Arkansas statute made no reference to an ERISA plan. Instead, the statute provided:

> all bonds, bills, notes, agreements, and contracts, in writing, for the payment of money or property, or for both money and property, shall be assignable.

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[13] The Supreme Court also found that Pennsylvania's law related to ERISA because it referenced employee welfare plans. In particular, the statute encompassed "any program group contract or other arrangement for payment of benefits." It further defined the aforementioned terms as "including but not limited to, benefits payable by a hospital plan corporation or a professional health service corporation." (Emphasis added). Hence, the Supreme Court found that Pennsylvania's law referenced employee benefits plans even though the statute (1) never explicitly mentioned such plans and (2) simply failed to exclude them from a catchall provision.

Plaintiffs contend that ERISA pre-empts the DRG scheme because the policy that contains the appeal procedure and Chapter 83 itself reference employee benefit plans. In particular, the appeal policy "denies the right to appeal a hospital bill to any plan participant if the 'third-party payer (commercial insurance, self-funded union, etc) requests an appeal on the basis of excessive charges'; or if the 'third party payer (commercial insure, self-funded union, etc.) does not reimburse the hospital on the DRG price per case. Moreover, in order to receive funds for uncompensated care a hospital must ask a patient whether he or she is covered by insurance including "whether such coverage is from a 'union welfare plan'."

Defendant's argue that these provisions do not refer to employee benefit plans, but merely use them as examples. In light of the *FMC* Court's opinion, defendants' argument fails, and this Court holds that the explicit reference to ERISA plans contained in the Chapter 83 provides further support for ERISA preemption.

Ark. Code Ann. § 4-58-102. The benefit plan at issue forbade assignment of benefits unless the benefit plan approved the assignment. Accordingly, the plan conflicted with Arkansas' statute that provided for unconditional assignment of such benefits.

In reaching its conclusion, the court noted that the statute negated a provision of the benefit plan. More importantly, the Eighth Circuit found that the law would subject the plan to inconsistent regulations throughout the country. Equally significant was the Eighth Circuit's opinion that the statute affected relationships among primary ERISA entities. Primary ERISA entities are — the employer, the plan, the plan fiduciaries, and the beneficiaries. In particular, the Eighth Circuit reasoned that the "assignment statute takes from the claims administrator who is a plan fiduciary, and gives to the beneficiaries control over who should receive payment of ERISA plan welfare benefits."[14]

Although the Supreme Court has interpreted § 514(a) broadly, the Court has cautioned that "some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to the plan.' " *Shaw*, 103 S. Ct. 2890 at 2901 n.21. Thus, ERISA would not pre-empt "a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Ingersoll-Rand*, 111 S. Ct. at 483; *see also Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989).

In *Mackey*, the Supreme Court held that ERISA did not pre-empt Georgia's garnishment statute that applied to any Georgia citizen, even when applied to benefits of participants in plans covered by ERISA. The fact that the law caused administrative burdens to ERISA plans did not suffice to pre-empt Georgia's garnishment statute.

Similarly, in *Aetna* the court concluded that ERISA did not pre-empt Connecticut's abandoned property laws. Aetna Life Insurance Company provided health and accident insurance. Often, Aetna would approve a claim for benefits, but the beneficiary would fail to collect the benefits. *Id.* at 143-44. The court held that ERISA's pre-emption clause did not prevent Connecticut from recovering the

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[14] In its decision the Eighth Circuit equated an effect on primary ERISA entities with the Supreme Court's often mentioned effect on an ERISA benefit plan's structure.

uncollected benefits. Connecticut's escheat law applied to all types of abandoned property, and it was insignificant that the abandoned property in this particular case consisted of the benefits provided under a plan covered by ERISA. *Id.* at 147-48.

Significantly, the law did not obligate the plan to cover certain benefits nor did it interfere with the calculation of benefits, the economic impact on ERISA plans did not threaten the purpose of ERISA to subject the plans to "national uniform supervision." *Id. See also Benefax Corporation v. Wright*, 757 F. Supp. 800 (W.D. Ky. 1990) (Even if Georgia licensing statutes that applied to administrators related to ERISA plans, affect would be too remote or tenuous for ERISA to pre-empt the statute. The statute applied to any administrator regardless of whether he or she administered a plan qualified under ERISA and "[did] not affect the relationship between principal ERISA entities other than to determine who can or cannot serve as an administrator.").

Additionally, the Supreme Court has held that laws that relate solely to benefits and not to benefit plans are not preempted by § 514(a). Accordingly, in *Ft. Halifax Packing Co. Inc. v. Coyne,* 482 U.S. 1, 107 S. Ct. 2211 (1987), the Supreme Court refused to find that ERISA pre-empted a Maine statute. The statute required an employer to pay employees a one time severance payment in the event of a plant closing. The Court ruled that the statute referred to a benefit and not to a benefit plan.

In so doing, the Court noted that the severance payment did not "establish a benefit plan," nor did it force an employer to "maintain a benefit plan." Further, the Court explained that the one time severance payment did not subject any benefit plan to inconsistent regulations. Finally, the Court concluded that the one time payment did not create continuing administrative hardships on an employee benefit plan. Therefore, the Court determined that ERISA did not pre-empt Maine's statute.

Plaintiff's correctly argue that the contested provisions in Chapter 83 relate to ERISA and are therefore preempted by § 514(a). Chapter 83 both forces the benefit plans to structure benefits in a particular manner and subjects the benefit plans to inconsistent regulations. The fact that the these provisions do not mention benefit plans directly and do not regulate the terms and conditions of such plans explicitly, has no bearing on this Court's findings.

In particular, the charges included in the DRG rate for uncompensated care, the shortfall for Medicare, and the discounts granted to certain payors, force the Benefit Plans to incur costs for the benefit of others if the Benefit Plans provide benefits to cover total hospital costs. The Benefit Plans themselves are not allowed to disburse funds to anyone other than a plan participant. As a result, Benefit Plans that are mandated to pay total hospital costs must disregard their express purposes.

Furthermore, in states in which hospital rates do not include costs for others, the Benefit Plans can abide by their express purposes. Hence, the plans are subjected to inconsistent regulations. Accordingly, plan members in different states receive different and disproportionate benefit amounts depending whether a given state's hospital rate setting policy includes charges beyond "actual hospital costs." Consequently, this Court finds that these provisions and the regulation promulgated thereunder frustrate ERISA's purpose of subjecting benefit plans to uniform federal regulations.

Additionally, ERISA itself forbids benefit plans from paying benefits for anyone other than a plan beneficiary. This proscription further compels this Court to find ERISA pre-empts Chapter 83's contested provisions and the regulations promulgated thereunder.[15] *See McLaughlin v. Rowley*, 698 F. Supp. 1333, 1339 (N.D. Tex. 1988) (ERISA pre-empted Texas Usury statute that prevented plan trustees from charging more than 10% interest on loans in light of ERISA provision that compelled "plan fiduciaries to obtain market rates on plan investments."); *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341, 1349 (8th Cir. 1991)

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[15] Defendants erroneously argue that Chapter 83 affects hospitals, not benefit plans. According to defendants, Chapter 83 forces hospitals to charge certain rates and does not foreclose the Benefit Plans from covering any portion of a participant's hospital bill. In light of the express purposes of both the Benefit Plans themselves and the dictates of ERISA, both of which prevent a Benefit Plan from covering costs of anyone except plan beneficiaries, this argument is at the least misleading. Moreover, defendants' argument simply ignores the Supreme Court's finding that ERISA pre-empts state laws that indirectly affect benefit plans.

Furthermore, defendants contend that Chapter 83 does not subject the Benefit Plans to inconsistent regulations because inconsistencies currently exist in the rates set by hospitals in various states. This argument is spurious. Plaintiffs are not advocating that hospitals in each state set identical rates. Instead, they argue that a state cannot include certain types of costs within its hospital rates. By including these type of costs, which other states might not include, New Jersey subjects Benefit Plans to inconsistent regulation.

(ERISA provision that prohibited assignment or alienation of ERISA plan benefits weighed in favor of pre-empting Arkansas law that unconditionally allowed assignment of any contract).

Moreover, because the purpose of the Benefit Plans and ERISA itself foreclose the plans from paying DRG rates, the participants in the plans lose any right to appeal the cost of their hospital bills. Again, only if the Benefit Plans choose to ignore the dictates of ERISA and pay DRG rates can the beneficiaries avail themselves of an appeal. This lack of parity with other hospital payors arises because of a Benefit Plan's administration and it is this relationship that undergirds the argument in support of pre-emption. Moreover, by virtue of their status, the Benefit Plans cannot qualify for an open enrollment discount. Importantly, the Benefit Plans must subsidize the recipients of these discounts. This further supports ERISA preemption.

Additionally, as opposed to the statutes at issue in both *Mackey*, and *Aetna Life Insurance*, the contested provisions in Chapter 83 are not simply tenuously connected to the Benefit Plans and which only affects the Benefit Plans by increasing their costs. Contrastingly, the disputed provisions affect the structure of the Benefit Plans themselves. Moreover, this Court finds that unlike the Supreme Court's decision in *Fort Halifax*, the offending provisions in Chapter 83 and the corresponding regulations do not simply constitute a benefit that forces the Benefit Plans to make a one time payment. Instead they subject the Benefit Plans to "ongoing administrative hardship." For these reasons, this Court finds that § 514(a) pre-empts ERISA.

Defendants argue, however, that ERISA does not pre-empt these provisions because they constitute a law of general application that has a too "tenuous, remote, or peripheral" effect on an employee benefit plan. Defendants rely primarily on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), to support their contention. In *Rebaldo* the Second Circuit held that § 514(a) did not pre-empt a New York statute that exempted small insurance funds which excluded employee benefit plans under ERISA from negotiating discounts with hospitals. Insurers such as Blue Cross were allowed to negotiate with hospitals for the discounts at issue.

The Second Circuit held that New York's law was solely a law of general application that failed to "affect the structure, administration or type of benefits provided by an ERISA plan." According to the court, the "mere fact that statute ha[d] some economic impact on the plan d[id] not require that the statute be invalidated."

As opposed to the statute at issue, the contested provisions in Chapter 83 do not only have an economic effect on ERISA plans. Instead, these provisions force Benefit Plans to structure benefits in a particular manner and subjects Benefit Plans to inconsistent regulations. Therefore, under the standard announced by *Rebaldo*, this Court would find that ERISA pre-empts Chapter 83.

Moreover, in light of recent decisions, the underlying rationale stated by the *Rebaldo* court is at the very least subject to question. In particular, the *Rebaldo* court reasoned that a "state law must purport to regulate the terms and conditions of employee benefit plans to fall within the preemption provision." As discussed above, the Supreme Court in *Ingersoll* faced this precise reading of § 514(a) and rejected it.

The *Rebaldo* court concluded that "containment of hospital costs is an exercise of police powers which should not be superseded by federal regulations unless there was a clear intent of Congress." In *Gilbert v. Burlington Industries. Inc.*, 765 F.2d 320, 327 (2d Cir. 1985), *aff'd*, 47 U.S. 901, 106 S. Ct. 3267 (1986), the Second Circuit revisited the weight to be given in an analysis under § 514(a) to a state's exercise of its police powers and attributed less weight to this factor than allotted to it by the *Rebaldo* court.

Specifically, the court in *Gilbert* stated, "in addition to being an exercise of traditional police power [a state law] must also affect the plan in too tenuous remote or peripheral a manner to warrant a finding that the law relates to the plan." Importantly, the *Gilbert* court pre-empted a state law that constituted an exercise of the state's traditional police powers because it found that the state law did not have a "remote or tenuous connection" to ERISA.

In *Boise Cascade Corp. v. Peterson*, 939 F.2d 632, 638 (8th Cir. 1991), the court similarly held that the minimum ratio rule that regulated the ratio of pipe-fitters to apprentices working on Minnesota job-sites and which had been effect since 1947 was pre-empted by ERISA. The Court specifically found that the state passed the minimum ratio law as an exercise of its police powers. In particular, the

court noted that the state enacted the statute at issue in order to protect its citizens' safety. Because the law failed to affect the plan solely in a "tenuous, remote or peripheral manner," however, the court held ERISA pre-empted the statute. *See also Arkansas Blue Cross & Blue Shield*, 947 F.2d at 1351 ("[W]e do not believe that whether the assignment statute is an exercise of traditional state authority favors or disfavors a finding of pre-emption"). Given that subsequent decisions have attacked *Rebaldo's* reasoning, this Court accords *Rebaldo* limited weight.

Other court decisions subsequent to *Rebaldo* that involved hospital rate setting schemes have found that ERISA preempted the scheme at issue. For example, in *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Insurance*, 771 F. Supp. 771, (E.D. La. 1991), the court held that ERISA pre-empted the statute that created the Louisiana Health Insurance Association (the "Association"). The Association administered and collected funding for a catastrophic health insurance program. The Association charged a fee to any "insurer," "insurance arrangement" or "self insurer" that provided medical benefits. A self-funded ERISA plan alleged that ERISA pre-empted the Association from collecting the fee for the catastrophic health insurance program.

The court rejected defendant's arguments that the statute was too tenuously connected to ERISA to warrant preemption. In so doing, the court reasoned that the plan "indisputably affects the relations among the principal ERISA entities" because it compelled the ERISA plans to pay certain types of benefits. Moreover, the statute mandated the ERISA plan pay costs of people who were not beneficiaries of the plans. This further supported the court's finding. As in *Bricklayers*, the DRG scheme forces the Benefit Plans to structure themselves in a certain manner, and to pay hospital costs that accrue to nonbeneficiaries. Hence, the same reasons that compelled the *Bricklayers Local* court to pre-empt the state statute, apply to the instant case.

Once again, in *United Health Services, Inc. v. Upstate Administrative Services Inc.*, 151 Misc. 2d 783, 573 N.Y.S.2d 851 (Sup. Ct. Broome Cty. 1991), the court found that ERISA preempted New York's rate setting scheme. Under this scheme, plans covered by ERISA paid a DRG rate while other plans paid actual cost. In finding that the relationship between ERISA and the plan at issue was

not too tenuous, the court held that the statute subjected the ERISA plans to inconsistent regulations. *Cf. General Motors Corp. v. Caldwell*, 647 F. Supp. 585 (N.D. Ga. 1986) (statute that regulated rates for prescriptions pre-empted by ERISA. Although not explicitly directed at ERISA plans, statute created an administrative scheme with which ERISA regulated plans had to comply).

Here, as in *United Health Services*, the statute at issue would result in subjecting the Benefit Plan to inconsistent regulations. Such inconsistencies would thwart the purposes of ERISA to create benefit plans subjected to uniform regulation. Thus, as in *United Health Services*, this Court finds that ERISA pre-empts certain costs and methods included in New Jersey's hospital rate setting scheme.[16]

D. Constitutional Attacks

Plaintiffs further allege that the manner in which hospital rates are set under Chapter 83 violates both the United States's Constitution and the Constitution of the State of New Jersey. Specifically, plaintiffs contend Chapter 83 deprives them of their procedural and substantive due process rights and the equal protection rights guaranteed to them under the Constitutions of the United States and the State of New Jersey; it constitutes a taking of property without just compensation under the United States Constitution; it imposes a special tax law in violation of the New Jersey Constitution; and it violates the New Jersey Constitution because it delegates taxing power from the Legislature to the Commissioner.

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[16] Defendants argue that both *Bricklayers Local No. 1* and *United Health Upstate Administrative Services* are distinguishable from the case at bar because the state statute at issue in those cases directly affected the ERISA plans. In light of the previous discussion that the Supreme Court has refused to limit ERISA pre-emption to state laws that directly affect ERISA benefit plans, this Court finds that defendant's argument has no merit.

Additionally, defendants cite *Bonser v. New Jersey*, 605 F. Supp. 1227, 1232 (D.N.J. 1985), as in support of their position. In *Bonser* the court opined that ERISA probably would not pre-empt New Jersey's system for setting hospital rates according to DRG category and not according to actual cost. Defendants' reliance on *Bonser* is misplaced for two reasons. First, the *Bonser* decision pre-dated the Supreme Court's most recent pre-emption opinion. These opinions further expand § 514(a)'s scope. Second, the costs added to the DRG rate for indigent care, bad debts, and the medicare cost shift were not at issue in *Bonser*.

1. Denial of Equal Protection

Plaintiffs assert two ways in which the provisions of Chapter 83 violate their equal protection rights under both the United States Constitution and the Constitution of the State of New Jersey. First, plaintiffs argue that the costs included in the DRG rate for indigent care, hospitals' bad debts and, costs for the Medicare shortfall violate the equal protection clause because these costs are borne only by hospital patients and not by all New Jersey's residents. Second, plaintiffs contend that the 11% discounts which are only available to plans with open enrollment and, are therefore, not available to the Benefit Plans denies plaintiffs their equal protection rights.

A plaintiff who challenges a statute or regulation that neither regulates a suspect class nor burdens the exercise of a fundamental right has a heavy burden. A Court must uphold a statute as long as it is rationally related to a legitimate governmental interest. *New Orleans v. Dukes*, 427 U.S. 297, 302, 96 S. Ct. 2513, 2516-17 (1976).

In determining whether legislation has a rational relation to a legitimate governmental interest, a Court must "accord wide latitude [to states] in the regulation of their local economies under their police powers, and rational distinctions may be made with substantially less than mathematical exactitude." A court cannot "judge the wisdom or desirability of legislative policy determinations made in areas that neither affect fundamental rights nor proceed along suspect lines." *Id.* Only the "wholly arbitrary act" can be deemed irrational. *Id.*

Consistently, courts have upheld regulations that disparately affect different classes of payors when challenged under the equal protection clause. For example, in *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 96 S. Ct. 2882, 2892-94 (1976), the Supreme Court upheld a federal statute that disparately charged different classes of mine workers for medical costs incurred by employees and former employees who contracted black lung disease. Under the statute, a miner's former employer had to pay the miner's medical expenses.

The employers argued that the statute denied them of due process

of law[17]; because it "spread costs in an arbitrary and irrational manner by basing liability upon employment relationships, rather than taxing all coal miine operators presently in business." 428 US. at 19; 96 S. Ct. at 2894. According to the employers, such an irrational statute compelled an operator who presently employed fewer people to be saddled with a liability which was disproportionate to the size of the employers current workforce. As a result, newer employers received a competitive edge and the older employers were unfairly apportioned a greater burden.

In holding that the statute had a rational basis, the Supreme Court gave great deference to Congress. In particular, the Court stated:

> [I]t is for Congress to choose between imposing the burden of inactive miners' disabilities on all operators, including new entrants and far-sighted early operators who might have taken steps to minimize black lung dangers, or to impose that liability solely on early operators whose profits may have been increased at the expense of their employees' health. . . . It is enough to say that the Act approaches the problem of cost spreading rationally;

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[17] The Supreme Court has declared that the due process clause of the Fifth Amendment contains an equal protection component applicable to actions in which a plaintiff challenges a United State's statute on the ground it treats different categories of people unfairly. The analysis under the due process clause is identical to the analysis under the equal protection clause of the Fourteenth Amendment. Plaintiffs contend that Chapter 83 arbitrarily discriminates among types of payors. In particular, plaintiffs declare that under Chapter 83 uninsured payors are charged "actual cost" but insured payors must pay the DRG cost that includes costs for the benefit of others. Plaintiffs assert that this violates their due process rights. Because plaintiffs challenge a state statute, plaintiffs should have asserted this cause of action under the equal protection clause.

Moreover, plaintiffs erroneously contend that all noninsured patients pay actual cost. Rather, only uninsured payors who successfully appeal pay actual costs. Therefore, this Court will construe plaintiffs claim as an equal protection challenge to the appeal process' differential treatment of insured and uninsured patients.

Even if plaintiffs alleged that the DRG costs violated their substantive due process rights because the charges deprived them of their property, this Court would still find that plaintiffs' claim was without merit. A substantive due process claim parallels a claim brought under the equal protection clause. In cases that do not implicate fundamental rights, the court must determine whether the regulation "is rationally related to furthering a legitimate state interest." *Meier v. Anderson*, 692 F. Supp. 546, 552 (E.D. Pa. 1988), *aff'd*, 869 F.2d 590 (3d Cir. 1989). As discussed in more detail below, the hospital rate setting system is rationally related to the furthering New Jersey's interest in containing hospital costs, ensuring hospitals remain financially solvent, and providing health care for its citizens. Therefore, a substantive due process claim would fail.

> whether a broader costspreading scheme would have been wiser or more practical under the circumstances is not a question of constitutional dimension.

See also United States v. Sperry Corporation, 493 U.S. 52, 110 S. Ct. 387 (1989) (due process challenge to statute that charged a fee to claimants who successfully recovered an award before the Iran-United States Claims Tribunal failed. Court found rational basis existed to compel only those who received a payment from the Tribunal to help subsidize the costs of running the Tribunal).

In the present case, the New Jersey Legislature has articulated a rational basis for the differential treatment given to plaintiffs. The Legislature has a rational basis for charging the cost of uncompensated care to plaintiffs. In accordance with its power to provide for the general welfare of its citizens, the Legislature has mandated that hospitals must provide care to anyone, regardless of ability to pay for the services. In order to follow this directive, Chapter 83 requires the DRG rate to include a charge for uncompensated care. Moreover, as part of its obligation to provide for the welfare of its citizens, one of Chapter 83's purposes is to ensure the economic solvency of its hospitals. Charging plaintiffs for uncompensated care is rationally related to both of these goals.

Although plaintiffs argue that this cost should be apportioned among all residents of New Jersey and not only among those who use the hospitals, this does not amount to a constitutional challenge. It is rational for New Jersey to force those who benefit from using the hospitals to bear the costs incurred by the hospitals for uncompensated care. Similarly, in order to provide for its citizens general welfare and to ensure the fiscal solvency of hospitals, it is rational for the Legislature to give discounts to plans that allow any citizen to enroll and to compel plans that do not have open enrollment to subsidize these discounts.

Finally, this Court finds that New Jersey's appeal procedure that effectively allows only uninsured patients to appeal the DRG charges that exceed the total cost by at least $250 has a rational basis. The appeal policy permits those who are more severely affected by hospital charges to obtain some financial relief. Thus, the process allows the State to provide for its citizens general welfare without overburdening a hospital's ability to remain fiscally solvent. For these reasons, this Court holds that plaintiffs' claims

brought under the Equal Protection Clause of the Federal Constitution have no merit.[18]

2. Taking of Property Without Just Compensation[19]

Plaintiffs further argue that the inclusion of certain costs in the DRG rate deprive plaintiffs of their property without just compensation. Consequently, plaintiffs contend these charges violate their rights under the Fifth Amendment which are applied to the states through the Fourteenth Amendment.

The Supreme Court has ruled that a statute or regulation which forces a person to expend money for the benefit of another does not constitute a physical taking of property. *See Sperry*, 493 U.S. 60, 110 S. Ct. 393 (1989); *Colorado Springs Production Credit Association v. Farm Credit Administration*, 758 F. Supp. 6, 12 (D.D.C. 1991). Accordingly, a regulatory takings analysis, and not a *per se* analysis applies to the regulations in the case at bar. *Colorado Springs Production Credit Association* at 12.

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[18] The courts apply the same analysis to claims that arise under New Jersey's equal protection clause as the courts apply to the equal protection clause contained in the Fourteenth Amendment. *See In Re C.V.S. Pharmacy Wayne*, 116 N.J. 490, 498 (1989), *cert. denied, Consumer Value Stores v. Board of Pharmacy*, 483 U.S. 1045 (1990) ("Legislation [will be] sustained if it is not arbitrary, capricious, or unreasonable, and the means selected bear a rational relationship to the legislative objective." . . . For a statute to be rationally related to the public interest, it need not be the best or only method of achieving the legislative purpose.") In fact, the New Jersey Supreme Court held that discounts given to Blue-Cross under the previous hospital rate setting scheme did not deny plaintiffs, a union health plan, their equal protection rights. Moreover, a due process analysis under the New Jersey Constitution follows an equal protection analysis. Therefore, plaintiffs' equal protection claims and due process claims fail under New Jersey's constitution for the same reasons that they are unfounded under the United States Constitution.

Additionally, New Jersey applies an equal protection analysis to determine whether a tax violates the State Constitution's prohibition against the levy of special taxes. *See Vreeland v. Byrne*, 72 N.J. 292, 298-99 (1977). Hence, in light of the above discussion even if under New Jersey law, the challenged costs were taxes, this Court would find that New Jersey has not imposed a special tax.

[19] The Hospital Defendants have instituted a counterclaim in which they allege that failing to increase hospital rates to compensate hospitals for the shortfall they face would constitute a taking of their property under both the United State's constitution and New Jersey's constitution. Assuming that plaintiffs have presented a ripe controversy to this Court, this Court finds that under the analysis announced by *Connolly*, losing their expected revenues does not constitute a taking of the Hospital Defendants' property. Likewise, this Court finds that the State Defendants inaction would not constitute a taking under the New Jersey Constitution.

There is no "set formula" that a court can apply to determine whether a regulation violates the Takings Clause. *Connolly v. Pension Guaranty Corp.*, 475 U.S. 211, 222, 106 S. Ct. 1018, 1025 (1986). Instead, courts determine whether a regulation violates the Takings Clause on an "ad hoc basis," in which the court focuses on "[the facts and] circumstances of each particular case." *Id.* The Supreme Court has announced a threeprong test to assist courts to decide whether a regulation constitutes a taking. Under this analysis the court considers:

> (1) the character of the governmental action; (2) the economic impact of the regulation on the claimant; and (3) the extent to which the regulation has interfered with investment backed expectations.

Id. at 1026 (citing) *Penn Central Transportation Co. v. New York City*, 438 U.S. 104, 124, 98 S. Ct. 2646, 2659 (1978).

The regulation at issue in *Connolly* required any employer who withdrew from a multi-employer fund to pay a fee that was related to an employers share of the plans "unfunded vested benefits." The regulation mandated such a fee in order to ensure that pension plans would be financed adequately.

Guided by this analysis, the *Connolly* court found that the federal regulation did not violate the takings clause. As to the type of governmental action, the Court found that this factor merited a finding that the regulation did not constitute a taking. Specifically, the Court found that the "Government [did] not physically invade or permanently appropriate any of the employer's assets for its own use." Instead, the government enacted the statute to protect participants in ERISA plans. The Court then concluded that "[such] an interference that adjusts the benefits and burdens of economic life to promote the common good [did] not constitute a taking." *Id.*

The Court then acknowledged that the regulation permanently deprived the plaintiff of any money it required him to pay. Nonetheless, the Court did not find that the regulation imposed a severe economic impact on plaintiffs. In so doing, the Court noted that the assessment on the employer related to the plans to which he had contributed. *Id.*

Finally, the Court found that the regulation failed to interfere with any of plaintiffs' investment backed expectations. In particular, the Court declared that pension plans were and had been regulated heavily by the Government. In light of the Court's findings, the Court held that the regulation did not violate plaintiffs rights under the takings clause.

Similarly, in *Meier v. Anderson*, 692 F. Supp. (E.D. Pa. 1988), the court found that the provision in Pennsylvania's Health Care Services Malpractices Act (the "Act") that established the Medical Profession Liability Catastrophe Loss Fund (the "CAT Fund") did not violate the takings clause. The Act required doctors to maintain malpractice insurance and to pay an annual surcharge to the CAT fund. This surcharge amounted to between 5% and 50% of a doctor's gross income and was calculated as a percentage of the Doctor's cost for malpractice insurance.

The Legislature enacted the surcharge to ensure adequate compensation to malpractice victims. The plaintiffs alleged that the surcharge violated their constitutional rights under the takings clause because it "placed the burden of compensating malpractice victims" on all doctors instead of on society in general or doctors who engaged in malpractice.

In reaching its decision, the court followed the analysis applied by the *Connolly* court. First, the court examined the type of action engaged in by the government. As in *Connolly*, the court found that Pennsylvania did not "physically invade or permanently appropriate any of plaintiffs' assets for its own use" but instead enacted a regulation that shifts economic burdens in order to "promote the common good."

Second, the court noted that as in *Connolly*, the Act permanently deprived the plaintiffs of the money that plaintiffs had to pay pursuant to the statute. The court further reasoned, however, that the regulation did not impose an arbitrary assessment upon plaintiffs. Instead, the assessment consisted of a percentage of a plaintiff's malpractice insurance costs. Furthermore, the court noted that plaintiffs benefitted from the Act. In particular, the Act excluded them from liability for malpractice claims that exceeded their insurance contributions.

Finally, the court concluded that plaintiffs had no reasonable investment backed expectations. First, the court explained that if the

Legislature had not passed the statute, plaintiffs would have expected to incur costs-for a malpractice judgment entered against them. Second, the court held that the state had regulated medicine over a long period of time. In view of these considerations, the court held the Act did not violate the takings clause.

In the instant case, as in the cases discussed above, plaintiffs have failed to show that the inclusion of certain costs in the DRG rate constitutes an unconstitutional taking of their property. New Jersey has not "physically invaded or permanently appropriated for its own use any of plaintiffs' assets." Instead, New Jersey has enacted Chapter 83 in order to promote the public good. Simply because this statute and the regulations promulgated under it, "adjusts the benefits and burdens of economic life," it is not transformed into a taking of plaintiffs property.

Furthermore, even though the statute permanently deprives plaintiffs of the costs associated with the DRG charges, this does not weigh in favor of this Court finding a taking. In particular, as in both *Connolly* and *Meier*, the amount of money exacted from plaintiffs is not determined on an ad hoc basis. The amount of money charged is directly related to the individual plaintiffs' hospital bill. Moreover, plaintiffs benefit from the Act for two reasons. First, it not only allows hospitals to maintain a higher level of care, but in some cases it also allows them to continue to provide health care. Moreover, the regulations would allow the individual plaintiffs to receive quality healthcare if they ever were unable to afford their hospital bills.

Finally, plaintiffs could not have had a reasonable investment backed expectation. New Jersey has regulated hospitals and hospital rates for many years. Moreover, even if New Jersey did not enact Chapter 83, hospitals would still charge plaintiffs for uncompensated care and the medicare differential so they could comply with their statutory obligation to provide hospital care for everyone regardless of that person's ability to pay. For these reasons, this Court finds that plaintiffs have failed to show that the costs included in the DRG rate rise to the level of an unconstitutional taking of property.[20]

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[20] This Court can dismiss summarily plaintiffs' procedural due process and illegal delegation of taxing power challenges to the DRG scheme. Plaintiffs' contend that the manner in which hospital rates are set constitutes an illegal delegation of

III. CONCLUSION

For the reasons expressed above, this Court grants defendants' motion for summary judgment as to defendants' state and federal constitutional claims. Further, this Court grants plaintiffs' motion for summary judgment as to the ERISA pre-emption claim. In particular, this Court finds ERISA pre-empts the sections of Chapter 83 and the corresponding regulations that mandate uncompensated care, allow the Medicare differential, allow the payor discounts, and allow for appeals of the DRG rate charged to a particular patient.

An appropriate order is attached.

Dated: May 27, 1992

ALFRED M. WOLIN, U.S.D.J.

(Continued)
the taxing power from the state to the Commissioner. Even if the charges included in the DRG rate constitute a tax under New Jersey law this court must dismiss plaintiffs' claim.

New Jersey has recognized that Legislatures have broad delegation powers. The Legislature must simply set out standards to guide the agency and its administrators. *Association of New Jersey College Facility, Inc. v. Board of Higher Education,* 112 N.J. Super. 237, 258 (Law Div. 1970). The rates at issue are set according to standards established by the Legislature and not determined solely at the whim of the Commissioner. In fact, the manner in which hospital rates are set has withstood these precise challenges. *In Re Schedule of Rates for Barnett Memorial Hospital,* 92 N.J. 31, 41-42 (1983); *In Re William B. Kessler Memorial Hospital,* 78 N.J. 564 (1979); *Borland v. Bayonne Hospital,* 72 N.J. 152, 158-59, *cert. denied,* 434 U.S. 817 (1977).

Additionally, even if plaintiffs challenge to the appeal process can be interpreted as a procedural due process claim, it would still fail. Plaintiffs have not established that New Jersey ever allowed them to receive the benefit of an appeal. Thus, New Jersey has never deprived plaintiffs of any benefit accorded them. Therefore, plaintiffs have no basis on which to advance a procedural due process claim to the appeal process.

United States District Court

FOR THE DISTRICT OF NEW JERSEY

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, et al.,

Plaintiffs,

v.

MORRISTOWN MEMORIAL HOSPITAL, et al.,

Defendants.

Civil Action No. 90-2639 (Consolidated)

ORDER

In accordance with the Court's Opinion filed herewith,

It is on this 27th day of May, 1992,

ORDERED that ERISA pre-empts the sections of Chapter 83, and the regulations promulgated thereunder, that allow for the inclusion of uncompensated care, the Medicare Cost Shift, Payor Discounts and appeals of the DRG rate for patients whose DRG rate exceeds total cost by at least $250.00; and it is further

ORDERED that the State Defendants are permanently enjoined from enforcing these provisions. This permanent injunction will take effect as of June 5, 1992; and it is further

ORDERED that this Court declines to exercise its pendent and supplemental jurisdiction over plaintiffs restitution claims; and it is further

ORDERED that plaintiffs' motion for summary judgment as to its state and federal constitutional claims is denied; and it is further

ORDERED that defendants' motion for summary judgment as to plaintiffs' state and federal constitutional claims is granted; and it is further

ORDERED that defendants' claim that this Court has no jurisdiction over this suit pursuant to the Tax Injunction Act is denied; and it is further

ORDERED that the State Defendants' immunity claim brought under the Eleventh Amendment is denied.

ALFRED M. WOLIN, U.S.D.J.